Washington State Responds

Providing Educational Information on HIV/AIDS & Other Infectious Diseases and Reproductive Health

May 2005

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The Washington State Department of Health HIV Prevention & Education Services, Client Services, and the Governor's Advisory Council on HIV/AIDS (GACHA) share a web address. Go to www.doh.wa.gov/hiv.htm for program access. You can also access the HIV Prevention & Education Services website at the old web address: www.doh.wa.gov/cfh/hiv_aids/prev_edu/.

Washington State Responds Quarterly Newsletter Now Electronically Distributed

Now that WSR is distributed electronically on our web site, we can send you an e-mail notification when the new issue is available online. In order to receive this notice please send your e-mail address with the subject title: WSR E-List. All you need to include in your note is your complete e-mail address. Please send to: barbara.schuler@doh.wa.gov.

HIV/AIDS Trainings to Meet State Licensing Requirements

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Anacortes (Skagit County)	(360) 299-1342 Jo Ann Hoover	4 hour 7 hour Video Courses	No charge	Offered by Island Hospital. For residents of Island, Skagit and San Juan Counties only.
Bellingham (Whatcom Co.)	(360) 733-3290	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $40 for 4 hour $60 for 7 hour	Offered by the Whatcom County-Bellingham American Red Cross.
Bellingham (Whatcom Co.)	(360) 715-8350	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 7 hour	Offered quarterly through Bellingham Technical College.
Bellingham (Whatcom Co.)	(360) 715-8350	4 hour Infectious Disease Prevention for EMS	$30 for 4 hour	Offered quarterly through Bellingham Technical College.
Bremerton (Kitsap County)	(360) 377-7307	4 hour 7 hour	$25 for 4 hour $30 for 7 hour	Offered by Kitsap Home Care Services Training Center.
Bremerton (Kitsap County)	(360) 475-7359	2.5 hour	$15 for 2.5 hour	Offered by Olympic College in Bremerton.
Bremerton (Kitsap County)	(360) 377-3761	2.5 hour 4 hour 7 hour	$21 for 2.5 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Bremerton (Kitsap and Pierce Counties)	(360) 405-0430 (253) 474-5879	2 hour 4 hour	$15 for 2 hour $15 for 4 hour	Offered by instructor Francis Hall. Also available in Pierce County.
Clallam County (Port Angeles)	(360) 417-2352 K. McDaniel	2 hour	$10 for 2 hour	Offered by Clallam County Health Department.
Clark County (Vancouver)	(360) 693-5821	2 hour 4 hour 7 hour	$10 for 2 hour $20 for 4 hour $50 for 7 hour	Offered by the American Red Cross.
Colville (Ferry, Stevens and Pend Oreille Counties)	1-800-827-3218 Angie	2 hour	No cost for 2 hour classes	Offered by Northeast Tri-County Health District.
Cowlitz County	(360) 414-5599	2 hour 4 hour 7 hour	$10 for 2 hour $30 for 4 hour $45 for 7 hour	Offered by Cowlitz County Health Department.
Coupeville (Island County)	(360) 678-5151	4 hour 7 hour	Call for info	Offered by Island County Health Department and Whidbey General Hospital.
Edmonds (Snohomish County)	(425) 640-1840	7 hour	$89 for 7 hour Also receive one credit.	Offered by Edmonds Community College.
Everett (Snohomish County)	(425) –259-9899 Anne Miles; Ext. 16 http:// www.pwnetwork.org/	2 hour 4 hour 7 hour	$20 for 2 hour $30 for 4 hour $50 for 5 hour	Offered by Positive Women's Network.
Everett (Snohomish County)	(425) 252-4103 Laura; Ext.12	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $30 for 4 hour $60 for 7 hour	Offered by the American Red Cross. Scholarships are available.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Grays Harbor	(360) 533-3431	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Grays Harbor and Pacific County	(360) 267-3404 (360) 267-3405	2 hour 4 hour 7 hour 10 hour	$30 for 2 hour $45 for 4 hour $75 for 7 hour $85 for 10 hour	Offered by Critical Incident Stress Management (CISM). They also offer First Aid/CPR classes.
Kirkland (King County)	(425) 739-8104 (425) 739-8112	7 hour	$69 for 7 hour	Offered by Lake Washington Technical College.
Mason County	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Mt. Vernon (Skagit County)	(360) 428-2151	4 hour 7 hour Videos	$25 handling fee for video tapes	Offered by Skagit Valley Hospital.
Mt. Vernon (Skagit County)	(360) 424-5291	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $35 for 4 hour $45 for 7 hour	Offered by American Red Cross.
Okanogan	(509) 422-7153 Corina	2 hour 4 hour 7 hour	$30 for 2 hour $30 for 4 hour $30 for 7 hour	Offered by Okanogan Health District.
Olympia (Thurston County)	(360) 352-8575	4 hour	$30 for 4 hour	Offered by the American Red Cross.
Olympia	(360) 352-2375	4 hour 7 hour	$30 for 4 hour $60 for 7 hour	Offered by United Communities AIDS Network (UCAN).
Puyallup (Pierce County)	(253) 841-3311	2 hour 4 hour 7 hour	$15 for 2 hour $40 for 4 hour $50 for 7+ hour	Offered by H.E.L.P. (HIV/AIDS Educational Learning Place) the C.P.R. First Aid Company.
San Juan County	(360) 378-4474	2 hour 4 hour 7 hour	$20 for 2 hour $20 for 4 hour $20 for 7 hour	Offered by San Juan County Health & Community Services.
Seattle/King Co. & South Snohomish Co.	(206) 784-5655 **www.healthinfonetwork.org**	2 hour 4 hour 7 hour	$10 for 2 hour $25 for 4 hour $40 for 7 hour	Offered by Health Information Network. They will also travel to your facility.
Seattle	800-783-2437	2.5 hour 4 hour 7 hour	$36 for 2.5 hour $44 for 4 hour $58 for 7 hour	Offered by Health Impact. Audio course available.
Seattle	(206) 726-3534	2 hour 4 hour 7 hour	$21 for 2 hour $38 for 4 hour $65 for 7 hour	Offered by the American Red Cross.
Seattle	(206) 850-2070 Betty Morgon aarthministry@yahoo.com	2.5 hour 4 hour 7 hour	$25 for 2.5 hour $45 for 4 hour $60 for 7 hour	African Americans Reach and Teach Ministries (AARTH)
Spokane	(509) 326-3330 Ext. 210	2 hour 4 hour	$20 for 2 hour $30 for 4 hour	Offered by the American Red Cross.

HIV/AIDS Trainings to Meet State Licensing Requirements, continued

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Spokane	(509) 324-1542	7 hour	$50 for 7 hour	Offered by the Spokane Regional Health District.
Spokane	(509) 928-1588 Ext. 16	7 hour	$45 for 7 hour	Offered by Visions Community Resources.
Spokane	(509) 236-2430 Becky Nauditt	2 hour 4 hour	$18.00 $30.00	Offered by Becky Nauditt
Tacoma (Pierce County)	(253) 841-3311 Barbara Miller	2 hour 4 hour 7 hour	$30 for 2 hour $40 for 4 hour $50 for 7 hour	Offered by C.P.R. Company.
Tacoma (Pierce County)	(253) 474-0600	2 hour 4 hour 7 hour	$15 for 2 hour $43 for 4 hour $55 for 7 hour	Offered by the American Red Cross.
Tacoma (Pierce County)	(253) 566-5020 Linda Finkas	7 hour 7 hour Independent Study	$40 for 7 hour $45 for video course	Offered by Tacoma Community College.
Vancouver	(360) 992-2939 Press Option One	2 hour 4 hour 7 hour	$30 for 2 hour $50 for 4 hour $60 for 7 hour	Offered by Clark College Continuing Education Program. Take home program that offers discounts for 2 or more students.
Walla Walla	(509) 527-4330	7 hour	$45 for 7 hour	Offered quarterly by Walla Walla Community College.
Wenatchee	(509) 664-3475	4 hour 7 hour	$20 for 4 hour $35 for 7 hour	Central Washington Hospital
Whitman County (Colfax)	(509) 397-6280	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
Whitman County (Pullman)	(509) 332-6752	4 hour Video Course 7 hour Video Course	$25 handling fee for tapes	Offered by the Whitman County Health Department.
White Salmon (Klickitat County)	(509) 493-1101	2 hour, 4 hour, 7 hour and other First Aid classes	$25 for 2 hour $30 for 4 hour $50 for 7 hour	Offered by Skyline Hospital.
Yakima	(509) 248-3628	7 hour	$50 for 7 hour	Offered by Planned Parenthood of Central Washington.
Yakima	(509) 457-1690	2 hour	$20 for 2 hour	Offered by the American Red Cross.
Yakima	(509) 853-2034 or 1-877-620-6202 http://www.fas-training.biz/	4 hour 7 hour and other First Aid classes	$40 for 4 hour $55 for 7 hour	Offered by First Aids & Safety Training.

HIV/AIDS Trainings to Meet State Licensing Requirements, Statewide

Location	Phone Number	2, 4 or 7 hour Courses	Cost	Other Details
Statewide	(206) 784-5655 http://www.healthinfonetwork.org/	HIV/AIDS 7-hour Video Course	$250	Offered by Health Information Network. Designed to assist health care facilities meet Washington State Licensing requirements.
Statewide	(206) 543-1047	HIV/AIDS Training Audiotape Course	$95 for 7.5 hours	Offered by U of W School of Nursing. Designed to assist health care facilities to meet WA State requirements.
Statewide	(425) 564-2012 http://www.bcc.ctc.edu	HIV/AIDS Self Study Program $100 Refundable Deposit	$60 for 4 hr. * $80 for 7 hr. *includes mailing	Offered by Bellevue Com. College Continuing Nursing Education and Health Information Network.
Statewide	(206) 320-9822	2 hour 4 hour 7 hour	$30 for 2 hour $45 for 4 hour $65 for 7 hour	Offered by the Empowerment Institute. Course may be offered at your site.
Statewide Internet Classes	(707) 937-0518 www.nursingceu.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Washington State HIV/AIDS internet course offered by Wild Iris Medical Education.
Statewide Internet Classes	1-800-346-4915 www.classesonline4u.com	2 hour 4 hour 7 hour	$20 for 2 hour $40 for 4 hour $70 for 7 hour	Online course offered by Prevention MD.
Statewide Internet Classes	(509) 628-1317 Kathleen Hayes www.designerwebsitesolutions.com	4 hour 2 hour	$40 for 4 hour $20 for 2 hour	Online course offered by Designer Website Solutions.

HIV Prevention Counseling and Testing Training Schedule for 2004-05

These one-, two- and three-day courses will assist health care providers and others develop necessary skills for providing pre- and post-test counseling for HIV testing, as required by Washington State law.

These courses are not intended for the general public.

Region	Trainer	Course Dates	
One (Spokane)	**Christopher Zilar** (509) 324-1542 The cost varies according to length of class.	June 15-16, 2005 Sept. 13-15, 2005	(2 day) (3 day)
Two (Yakima)	**Deborah Severtson-Coffin** (509) 454-3322 The cost for the 2-day class is $85.	May 12-13, 2005 June 16-17, 2005 June 8-10, 2005 June 30-July 1, 2005 Oct. 27-28, 2005	(2 day) (2 day) (3 day) (2 day) (2 day)
Three (Everett)	**Eric Hatzenbuehler** **Jordan Bower** (425) 339-5275	Aug. 30-31, 2005 July 18-20, 2005 Nov. 28-30, 2005	(2 day) (3 day) (3 day)
Four (Seattle)	**Robert Marks and Mark Alstead** (206) 296-4649 or e-mail to: diane.ferrero@metrokc.gov The cost for the 2-day class is $125. The cost fot the 3-day class is $175.	May 10-12, 2005 Oct. 18-19, 2005 Sept. 27-29, 2005	(3 day) (2 day) (3 day)
Five (Tacoma)	**Kim Ingram** and **Moni Muraki** (253) 798-2939 The cost varies according to length of class.	May 26-27, 2005 June 24, 2005 July 27-29, 2005 Oct. 26-28, 2005	(2 day) (1 day) (3 day) (3-day)
Six (Vancouver)	**Beth McGinnis** (360) 397-8111 The cost for the 2-day class is $100.	July 27-29, 2005 Nov. 2-4, 2005	(3 day) (3 day)

Calendar

May 9, 2005

CDC and Emory University's Rollins School of Public Health are sponsoring a course, "**Introduction to Public Health Surveillance**," May 9-13, 2005, in Atlanta, Georgia. The course will provide practicing public health professionals with the theoretical and practical tools necessary to design, implement, and evaluate effective surveillance programs. Topics include overview and history of surveillance systems; planning considerations; sources and collection of data; analysis, interpretation, and communication of data; surveillance systems technology; ethics and legalities; state and local concerns; and future considerations. For additional information and applications go to **http://www.sph.emory.edu/epicourses** or telephone (404) 727-3485.

May 16, 2005

The Dallas Prevention Training Center hosts this five day workshop providing STD/HIV Spanish-speaking front-line providers with information needed to implement Community PROMISE with fidelity and **build capacity for organizations serving monolingual Latino/Latina communities**. This course will be provided in Spanish May 17-20, 2005. The one day overview course on May 16, 2005 will be followed by the one day Community Identification course on May 17, 2005. The training program will continue with the three day Role Model Stories and Peer Advocates course on May 18, 19 and 20, 2005. There is no fee for this workshop. For further questions, please contact Oscar Gonzalez at **oscar.gonzalez@utsouthwestern.edu** or telephone (214) 645-7356.

June 6, 2005

STD Intensive – This 5-day course, designed for clinicians with ***at least 6 months*** STD exam experience, addresses the prevention, diagnosis and management of sexually transmitted diseases through didactic and practicum training. The 3-day didactic portion may include the following topics: STD Overview, genital herpes, human papillomavirus, STD-Related Syndromes in Women (Vaginitis, Cervicitis, and PID), Syphilis, Genital Dermatology, STD-Related Syndromes in Men, Update on GC Therapy, Partner Management, Viral Hepatitis, Assessment of STD-Related Risk Behavior and Targeted Risk Reduction, Contraceptive Update and STDs in Adolescents: Special Concerns. The 2-day clinical practicum includes performing STD examinations for both male and female clients in the presence of a skilled preceptor. Laboratory training includes wet mount and microscopy procedures directed by a preceptor. The practicum sessions are scheduled individually to take place within 1-2 months following the didactic portion of the course. The registration fee for the STD Intensive course is $300.

STD Update- The STD Update course is the 3-day didactic portion of the STD Intensive course described above. The course is designed for clinicians. The registration fee for the STD Update course is $200. Please see the Seattle STD/HIV Prevention Training Center website at **www.seattlestdhivptc.org** or call Ronnie Staats at 206-685-9848 for details, space availability and online registration information.

July 18, 2005

Applications are being accepted for the 13th Annual **Principles of STD/HIV Research Course** at the University of Washington. The course will be held July 18-28, 2005. The registration fee is $450.00 and the deadline for registration is May 2, 2005. Detailed course information and online registration are available at: **http://depts.washington.edu/pshr.** This training is provided by the UW Center for AIDS and STD, and is sponsored by the National Institutes of Health and the Centers for Disease Control and Prevention.

August 25, 2005

Basic STD Lab Skills- This 1-day workshop focuses on the handling, performance, and interpretation of basic lab tests, including wet mount and Gram stain, used in the diagnosis of various STD-related syndromes such as vaginitis and urethritis. Instruction is provided through a combination of lecture, class discussion, and microscopy practice. It is designed for the laboratorian or health care provider new to microscopy or in need of review of basic techniques. This course is held at the Washington State Public Health Laboratory, in Seattle. There is a $150 registration fee for this course.

August 26, 2005

Venipuncture Techniques- this 1-day course instructs students in the basics of blood drawing techniques, including tourniquet tying, finding and preparing a suitable vein, appropriate blood tube uses, proper materials disposal and safety issues. The class is taught through lecture and hands-on practice on both simulated models and other course participants (not mandatory), and is designed for health care workers serving high-risk populations. This course is held at the Washington State Public Health Laboratory in Seattle. There is a $150 registration fee for this course.

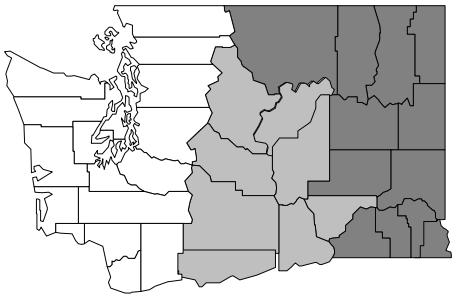
Volunteer Opportunities

Volunteers are needed as one-on-one mentors, summer camp counselors and camp program staff. **Rise n' Shine's** service area includes children and teens affected by HIV and AIDS living in King, Pierce, Snohomish and other Puget Sound counties. We are currently looking for stable, compassionate and giving individuals to volunteer with this special group of children. The next new volunteer training is scheduled for May 21st and 22nd . For a volunteer application and information, please contact Danica Smith at (206) 628-8949 ext. 210, e-mail **Danica@risenshine.org** or visit **www.risenshine.org**.

Multifaith Works AIDS CareTeam Volunteer Training will be held Saturday, May 21st , 2005, 8:30 am to 4:45 pm, Lake Burien Presbyterian Church, 15003 14th Avenue SW, Burien.This training is for people interested in becoming HIV/AIDS volunteers as members of congregation-based AIDS CareTeams. Through their caring attitudes, AIDS CareTeam members encourage empowerment, acceptance and hope. Please register by Friday, May 13th. For further information, call (206) 324-1520 ext. 233 or email **careteams@multifaith.org**.

Shanti Volunteer Training is on June 4th and 5th and 11th and 12th , 2005. Volunteers provide one-to-one, nonjudgmental emotional support to people living with HIV/AIDS, cancer, MS, and other life-threatening illnesses. The Shanti training and volunteer experience has been described as life-changing for many volunteers. For more information, please call (206) 324-1520 ext. 3 or email **shanti@multifaith.org**.

Regions 1 & 2



Region One (dark area) includes Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman Counties. The Region One AIDSNET Office is in Spokane and the Coordinator is Barry Hilt at (509) 324-1551.

Region Two (gray area) includes Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat and Yakima Counties. The Region Two AIDSNET office is in Yakima and the Coordinator is Wendy Doescher at (509) 249-6503.

Transitions

The **Spokane Regional Health District HIV/AIDS and Reproductive Health Program** welcomes **Darcy Southwell** into the office as administrative support..

Announcements

Yakima Health District HIV staff continues to offer HIV education and high risk counseling and testing to Yakima County inmates in both the county jail and the Restitution Center in Yakima. Yakima staff will also start much needed education, counseling and testing twice a month for high risk youth at the Juvenile Justice Center for Education.

Yakima Health District is beginning their **HIV/AIDS educational group sessions with MSM migrant farm workers**. Counseling and testing will be offered to those with high risk behaviors. This will be offered throughout Yakima County from March through October 2005.

Needle Exchange continues every Wednesday and Friday in Yakima, and every second Tuesday of the month in the lower valley. Second and third year medical residents attend the needle exchange to help individuals with abscesses and other medical problems; also, there is a Yakima Health District nurse attending every other needle exchange to help out.

Yakima Health district continues to support the program **Project Smart (TARR)** teaching addicts risk reduction through testing and counseling; many of those that attend TARR are from the needle exchange.

Benton-Franklin Health District has a new part-time advocate, **Rosario Carrera**, RN, who will be working with HIV-infected and affected women and children. Some of the areas that she will be focusing on include a monolingual Spanish-speaking women's support group. These efforts will be coordinated with Benton-Franklin case management and the Tri-Cities Chaplaincy CARES program. Title IV is funding this position through CareBearers in Yakima.

In January, **Benton-Franklin Health District case management team** began facilitating the start of a **client committee.** This committee will address clients' needs and coordinate activities to improve clients' lives while serving as an advisory to the Benton-Franklin case management team and the Tri-Cities Chaplaincy CARES Program.

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The **HIV-Hepatitis C (HCV) AIDS Substance Abuse Program** (HASAP), a collaborative effort between the Spokane Regional Health District's Community Health Intervention and Prevention Services and the Reproductive Health Program, will no longer be funded. The program was designed to provide substance abuse treatment and support services to clients living with HIV, HCV or both. **Lori Edwards**, the chemical dependency professional who was the program counselor, will be greatly missed by clients and staff alike.
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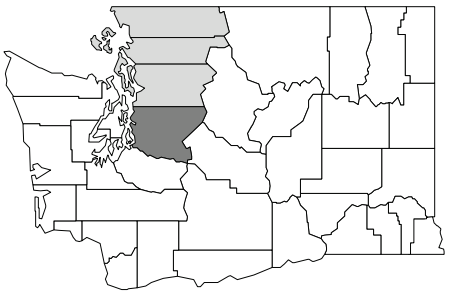
REGIONS 3 & 4



Region 3 (gray area) includes Island, San Juan, Skagit, Snohomish and Whatcom Counties. The Region 3 AIDSNET office is in Everett and the Coordinator is Alex Whitehouse at (425) 339-5211.

Region 4 (dark area) is King County. The Region 4 AIDSNET office is in Seattle and the Coordinator is Barbara Gamble, who can be reached at (206) 205-0937.

TRANSITIONS

April 1 was the last workday at Snohomish Health District for **Dennis Worsham**, HIV/STD Prevention Program Manager since June 2001, and Health Educator in the HIV/AIDS program from 1993 to 1999. Dennis relocated to Public Health-Seattle and King County, where he is TB Program Manager. He can be reached at dennis.worsham@metrokc.gov, or (206) 731-4579.

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The **HIV Epidemiology Program at Public Health-Seattle & King County** is pleased to announce that **Dorothy Gibson** has started as the new Project/Program Manager IV. Dorothy will oversee all the fiscal, personnel, and other operational matters for the program. She brings a strong background in public health, with years of experience at both the Texas Department of Health and the Washington State Department of Health. She is knowledgeable on HIV/AIDS issues-she helped start AIDS surveillance activities in Texas two decades ago. Welcome, Dorothy!

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After eleven-plus years **Multifaith Works** thanks Rabbi Anson Laytner for an outstanding period of service to the agency, and wishes him congratulations upon a new venture. Anson became the Executive Director of the American Jewish Committee (Seattle Chapter) on February 1, 2005. Barbara Green has been hired to serve as Interim Executive Director. Barbara has served in leadership roles within non-profit organizations for more than 25 years. A Multifaith Works Executive Director Search Committee has been named, and the Board has secured the services of Laura Retzler of Nonprofit Recruitment Services to assist with the executive search process.

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Evergreen AIDS Foundation (EAF) in Bellingham, Washington, bid farewell to Community Programs Manager (CPM), **Darren G. Davis**, and wish him the best as he moves to California to continue his career directions in publishing and filmmaking. **Rebecca L. Hutchins**, from Indiana, will be the new CPM. Becky came to sign up as a volunteer; her resume (museum collections manager and adjunct professor, anthropologist and archaeologist…) was so impressive that she was enticed to join the staff instead. She brings professionalism, style and a wealth of knowledge to the position.

The Board of Directors elected new officers to serve in 2005: President **Linda Luttrell**, Western Washington University; Vice President **Shane Crowder**, Alcoa Intalco Works; Treasurer **Terry Hinz**, Whatcom County Health and Human Services; and Secretary **Sara Moore**, a student at WWU. EAF extends grateful thanks to retiring directors Gary Cocca, Hal Gloff and John Huff, who have contributed their time and talents in the effort to enhance the community and the lives of EAF's amazing clients.

Due to the tireless efforts of Case Manager **Michelle Dever** and a grant from Broadway Cares/Equity Fights AIDS, clients have begun accessing **alternative therapy services**, including massage, acupuncture and chiropractic, from local providers. Thanks to a grant from the local branch of **Key Bank**, Case Manager, **Mel Taylor** hosted a "Return to Work" seminar at the end of February as well. This half-day session included lunch, personal folios and four presenters covering subjects from resumes to disclosure. Eight clients also attended AIDS Awareness and Action Day in Olympia at the end of February, speaking throughout the day to local legislators about their personal stories of living with HIV disease.
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EAF and the community are anticipating the following events:

March 26th - Seattle Men's Chorus concert in the beautiful Mt. Baker Theatre.

April 23rd - "Taking Care of Our Greatest Resource… Ourselves," a **positive women's retreat** focusing on practical tools and techniques for stress reduction, relaxation, body awareness and personal growth.

April 2nd - Reveal party of the **Queer Plan for the Straight Woman**; Lucky lady Joanie will be made over by EAF's local fabulous five.

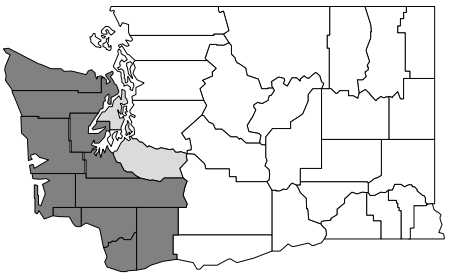
May 1st - EAF's second **annual garden party** and **silent auction** at the gracious Lairmont Manor, with this year's theme of **All Things Seem Possible in May** featuring an elegant buffet lunch, live music, a keynote speaker and auction items with a horticultural theme.

Announcements

In an effort to provide direct and consistent service to the families affected by AIDS in Snohomish County, **Rise n' Shine** has brought **Jim Thompson** on staff . Besides personal experience, Jim has also: served on the board of Snohomish County AIDS Project; been a Client Services Coordinator at HOPWA; and, has actively participated in the Snohomish County Speakers Bureau. Rise n' Shine is very excited to welcome Jim to the staff.

Health Information Network continues to provide live HIV/AIDS courses for child and health care providers. The 2004 HIV/AIDS video kit is now in use at 150 facilities statewide. Many facilities have logged onto the web site to use the link to the free preview at www.healthinfonetwork.org; click on "Services", then "Video", and click on the link to the preview at the bottom of the page. An online version is nearly ready to launch.

Regions 5 & 6



Region 5 (gray area) includes Kitsap and Pierce Counties. The Region 5 AIDSNET office is in Tacoma and the Coordinator is Mary Saffold at (253) 798-4791.

Region 6 (dark area) includes Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum Counties. The Region 6 AIDSNET office is in Vancouver and the coordinator is David Heal at (360) 397-8086.

Transitions

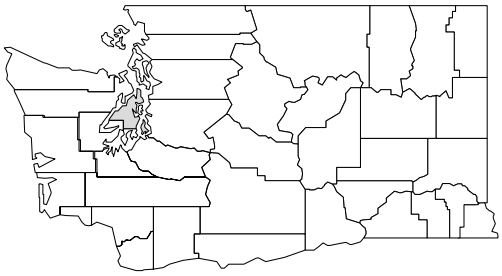
Clark County has a new Case Manager, **Staci Sturges**, MSW. Staci's background is in medical social work; she comes to the department from the State of Washington DSHS. Welcome aboard Staci!

Announcements

The Region 6 Prevention Planning Committee is in the preparation stages for a formative evaluation project with Hispanics and Latinos in the region. If you are currently doing or have done work with the Latino population and are using a scientifically-researched model (it could have been adapted or tailored) please contact Beth McGinnis, Region 6 AIDSNET, as she is interested in speaking with you about the model to consider it for possible use in the formative evaluation project.

STATEWIDE NEWS

GUIDELINES FOR SEXUAL HEALTH INFORMATION AND DISEASE PREVENTION



The Washington State Department of Health &

The Office of Superintendent of Public Instruction

January 13, 2005

FOREWORD

The Washington State Department of Health (DOH) and the Office of Superintendent of Public Instruction (OSPI), jointly established The Guidelines for Sexual Health Information and Disease Prevention. The voluntary guidelines were developed in response to a bipartisan request from 41 state legislators.

These guidelines provide a framework for medically and scientifically accurate sex education for Washington youth. DOH and OSPI strongly encourage all school districts, community-based organizations, juvenile detention centers, and tribal health programs vested in adolescent health to participate in the distribution of the guidelines. The guidelines are available for public view at the following Web site: http://www.k12.wa.us/CurriculumInstruct/healthfitness/

PURPOSE OF THE GUIDELINES

1. To describe effective sex education and its outcomes;
2. To provide a tool for educators, policy-makers and others to evaluate existing or new programs, curricula or policies;
3. To enhance and strengthen sex education programs;
4. To educate schools and school districts, community organizations, communities of faith, the public, the media, policymakers and others involved in educating youth.

THE GOAL OF SEX EDUCATION

Achieving healthy sexuality is a developmental process from birth to senior adulthood; so is learning about sexuality. In the early years, the foundation for mature adult sexuality is laid with such building blocks as healthy self-esteem, positive body image, good self-care, effective communications, respect for others, caring for family and friends, and a responsibility to community. As an individual matures, other essential elements are added such as understanding body changes, sexual intimacy and commitment; knowing and using health enhancing measures, such as health exams, abstinence and protection; and recognizing the joys and responsibilities of parenting.

Washington State's HIV/AIDS education (RCW 28A.230. 070) and Bully and Harassment Policy (WAC 392-190-056) requirements are supported by the objectives of sex education. The goal of sex education is **safe and healthy people**. These are individuals who:

- Express love and intimacy in appropriate ways.
- Avoid exploitative or manipulative relationships.
- Recognize their own values and show respect for people with different values.
- Take responsibility for and understand the consequences of their own behavior.
- Communicate effectively with family, friends and partners.
- Talk with a partner about sexual activity before it occurs, including sexual limits (their own and their partner's), contraceptive and condom use, and meaning in the relationship.
- Plan effectively for reproductive health and disease prevention regardless of gender.
- Seek more information about their health as needed.

GUIDELINES FOR SEXUAL HEALTH INFORMATION & DISEASE PREVENTION

Evidence suggests that sex education programs that provide information about both abstinence and contraception can delay the onset of sexual activity in teenagers, reduce their number of sexual partners and increase contraceptive use when they become sexually active. These programs:

- Are age and culturally appropriate.
- Use information and materials that are medically and scientifically accurate and objective.
- Encourage and improve communication, especially around growth and development, with parents/guardians and other trusted adults. (The quality of parent-child communications about sex and sexuality appears to be a strong determinant of adolescents' sexual behavior).
- Identify resources to address individual needs, for present and future concerns and questions.
- Enlighten young people to develop and apply health-promoting behaviors, including disease prevention and detection and accessing accurate health information that is age appropriate.
- Provide information about sexual anatomy and physiology and the stages, patterns, and responsibilities associated with growth and development.
- Stress that abstinence from sexual activity is the only certain way to avoid pregnancy and to reduce the risk of sexually transmitted diseases (STDs), including HIV.
- Acknowledge that people may choose to abstain from sexual activity at various points in their lives.
- Address the health needs of all youth who are sexually active, including how to access health services.
- Provide accurate information about STDs including how STDs are and are not transmitted and the effectiveness of all FDA approved methods of reducing the risk of contracting STDs.
- Provide accurate information about the effectiveness and safety of all FDA-approved contraceptive methods in preventing pregnancy.
- Provide information on local resources for testing and medical care for STDs and pregnancy.
- Promote the development of intrapersonal and interpersonal skills including a sense of dignity and self-worth and the communication, decision-making, assertiveness and refusal skills necessary to reduce health risks and choose healthy behaviors.
- Recognize and respect people with differing personal and family values.
- Encourage young people to develop and maintain healthy, respectful and meaningful relationships and avoid exploitative or manipulative relationships.
- Address the impact of media and peer messages on thoughts, feelings, cultural norms and behaviors related to sexuality as well as address social pressures related to sexual behaviors.
- Promote healthy self-esteem, positive body image, good self-care, respect for others, caring for family and friends and a responsibility to community.
- Teach youth that learning about their sexuality will be a lifelong process as their needs and circumstances change.
- Encourage community support and reinforcement of key messages by other adults and information sources.

COMMON CHARACTERISTICS OF EFFECTIVE SEX EDUCATION PROGRAMS

Dr. Douglas Kirby, a Senior Research Scientist at Education, Training, Research (ETR) Associates, conducted a review of sex education programs that have been rigorously evaluated using quantitative research and shown to be effective in reducing risk-taking behaviors. In his recent landmark review of teenage pregnancy prevention programs, Dr. Kirby identified ten common characteristics of these types of programs. Specifically, such programs:

- Deliver and consistently reinforce a clear message about abstinence as the only sure way to avoid unintended pregnancy and STDs; and about using condoms and other forms of contraception if they are sexually active. (This appears to be one of the most important characteristics that distinguish effective from ineffective programs.)
- Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.

- Are based on theoretical approaches that have been demonstrated to influence other health-related behavior and identify specific important risky behaviors to be targeted.
- Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse for protection against pregnancy and STDs.
- Include activities that address social pressures on sexual behavior.
- Provide modeling and practice of communication, negotiation and refusal skills.
- Employ a variety of teaching methods designed to involve the participants and have them personalize the information.
- Incorporate behavioral goals, teaching methods and materials that are appropriate to the age, sexual experience, and culture of the students.
- Last a sufficient length of time to complete important activities adequately—i.e., more than a few hours. (Generally speaking, short-term curricula may increase conceptual understanding, but do not have measurable impact on the behavior of teens).
- Select educators who believe in the program they are implementing and provide them with quality training.

It should be noted that the absence of even one of the above characteristics appeared to make a program appreciably less likely to be effective.

GLOSSARY

Effective programs: are those programs that have been shown, in sound peer-reviewed qualitative or quantitative research, to be associated with a reduction in sexual risk-taking behaviors, an increase in health protective behaviors and other associated benefits such as increased self-esteem or enhanced respect for others.

Medically and scientifically accurate: refers to information that is verified or supported by research in compliance with scientific methods and published in peer-review journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the American College of Obstetricians and Gynecologists (http://www.acog.org), the Department of Health (http://www.doh.wa.gov), and the Centers for Disease Control and Prevention (http://www.cdc.gov).

Sexuality: is a significant aspect of a person's life consisting of many interrelated factors including but not limited to sexual anatomy, physiology, growth and development; gender, gender identity and gender role/ expression; sexual orientation and sexual orientation identity; sexual behaviors and lifestyles; sexual beliefs, values and attitudes; body image and self-esteem, sexual health; sexual [thoughts and feelings]; relationship to others; [and] life experiences.

Sex education: refers both to teaching about sexuality and to the lifelong process of learning about sexuality. Typically, the main objectives of formal sex education programs are as follows:

1. To help foster responsibility regarding sexual relationships, including addressing abstinence, resisting pressure to become prematurely involved in sexual activity, and encouraging the use of contraception and other sexual health measures;
2. To provide learners with an opportunity to explore and assess their own values, to increase self-esteem, create insights concerning relationships with others, and understand their obligations and responsibilities to self and others;
3. To help learners develop important interpersonal skills--such as communication, decision-making, assertiveness, peer refusal skills--to create more satisfying and healthy relationships;
4. To provide learners with information about human sexuality and relationships, including but not limited to the topics listed above under "Sexuality".

CONTACT INFORMATION

Department of Health

Child and Adolescent Health Program: 360-236-3547

Office of Superintendent of Public Instruction

Health/Fitness Education and HIV/STD Prevention Program: 360-725-6364

For the complete guidelines, please go to http://www.k12.wa.us/CurriculumInstruct/healthfitness/.

State Model KNOW: HIV/STD Prevention Curriculum Revised for Grades 7/8

A newly revised *KNOW: HIV/STD* version of the state model curriculum for grades 7 and 8 was released during January by the Office of Superintendent of Public Instruction (OSPI). Trainings will be offered through educational service districts for grades five through twelve beginning in April. Health educators from each local health district were invited to attend a training of trainers on March 15th. The AIDS Omnibus Act requires all public schools to provide HIV instruction for students in grades 5-12 and that the OSPI provide a model curriculum as an option for schools. The revision for grades 7/8 follows a grade 5/6 revision that was released last year. The OSPI intends to begin work on the high school program during the next year.

In addition to revisions to the teacher information materials, other changes include a section on Hepatitis (A, B and C) in seventh grade and moving the major focus on sexually transmitted diseases to eighth grade. A power point presentation is provided on a CD for those with access to this technology. OSPI is grateful to the Department of Health for assistance in assuring medical accuracy and providing technical guidance as the revisions were developed.

Order the curriculum through OSPI by going to www.k12.wa.us/curriculuminstruct/ healthfitness. You may also check for training dates and locations at this site. For questions regarding health and fitness education in Washington schools you may contact Pam Tollefsen at 360-725-6364, TTY 360-725-6017, or by e-mail at pamt@ospi.wednet.edu.

Announcements

The **National Alliance of State and Territorial AIDS Directors** (NASTAD) is composed of the AIDS Directors from each state and territory. Jack Jourden, the AIDS Director for Washington State, was elected as 'chair-elect' at the 14th annual NASTAD meeting. Jack will serve as chair in 2006-2007. The primary issues for state AIDS programs are: assuring the reauthorization of the Ryan White Care Act that is due in the fall of 2005 and maintaining HIV Prevention funding from federal partners.

The **State Planning Group** has a new at-large representative from the Tri-Cities area, **Kathy Lord**. She is currently a member of the Region 2 Planning Group and has been actively involved for the past year in prevention efforts. Welcome, Kathy!

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PositiveVOICE Washington is preparing to conduct the first-ever **Statewide Survey of HIV/AIDS Volunteers** in Washington. The project's goal is to learn more about the thousands across the state who give of their time in HIV/AIDS prevention and care activities. The data will be shared with volunteer program managers to help them in recruitment, training, recognition, and retention of volunteers.

The response to HIV/AIDS began two decades ago as an all volunteer effort, and PositiveVOICE hopes to foster a renewed interest in volunteer roots. The survey will be administered both via a web site, and by paper copies that will be distributed by the programs/agencies that use HIV/AIDS volunteers.

If you are responsible for recruiting, training, or honoring any HIV/AIDS volunteers, be sure your volunteers are included in the project by contacting PositiveVOICE for complete participation information. There is no cost, and participation ensures your volunteers' ideas and concerns are part of the results. PositiveVOICE plans to start the survey by late May, and will accept responses for at least two months. To participate in the **Statewide Survey of HIV/AIDS Volunteers**, contact Jim Musslewhite, President of PositiveVOICE Washington, via email: Jim@PositiveVOICE.org or 360.570.8380. For general information about PositiveVOICE's mission, Board, and activities, see www. PositiveVOICE.org.

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On April 19, 2005 Washington State lost a dedicated leader and activist in the battle against HIV/AIDS. **Sam Soriano** brought a unique blend of determination, compassion and respect to each of the many roles he embraced. Sam exemplified commitment and leadership as Community Co-Chair of the State HIV Prevention Planning Group, member of the Early Intervention Steering Committee, Prevention Co-Chair of the Region 4 Planning Council, as well as playing an active role in national advocacy organizations. As Jesse Chipps put it "Sam put the V in volunteer". Those of us

who knew and loved him will miss his smile and laughter. We can hold up our memories of Sam as a leader who persevered through many personal challenges because he knew he was making a difference. And make a difference he did!

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The State Planning Group has a new at-large representative from the Tri-Cities area, **Kathy Lord**. She is currently a member of the Region 2 Planning Group and has been activitely involved for the past year in prevention efforts. Welcome Kathy!

State Planning Group

The State Planning Group (SPG) is scheduled to meet the 4th Thursday of the month from 9:00 A. M. to 2:30 P.M. The May and June meetings are tentatively cancelled. The next meeting will be July 28, 2005. The meetings are held in SeaTac. For specific meeting locations and topics contact Harla Eichenberger at: (360) 236-3424 or visit: http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/HIV_Community_Planning.htm.

Community Planning

The six **AIDSNET Regions** continue to coordinate the local planning process through meetings of the Regional Planning Groups (RPGs). This process absolutely requires input and participation from members of the community infected and affected by this epidemic. Are you willing to become one of the voices that support effective prevention efforts? If so, please contact your local Regional Coordinator or DOH contact in the list below, for more information.

Barry Hilt - Region 1 AIDSNET (Spokane) – (509) 324-1551

Wendy Doescher – Region 2 AIDSNET (Yakima) – (509) 249-6503

Alex Whitehouse – Region 3 AIDSNET (Everett) – (425) 339-5211

Barb Gamble – Region 4 AIDSNET (Seattle) – (206) 205-0937

Mary Saffold – Region 5 AIDSNET (Tacoma) – (253) 798-4791

David Heal – Region 6 AIDSNET (Vancouver) – (360) 397-8086

Brown McDonald – State Planning Group (SPG) – (360) 236-3421
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HIV Prevention Focus

Planning, Implementing & Evaluating Interventions

By Frank E. Hayes; DOH HIV Prevention and Education Services

Planning, implementing, and evaluating interventions must be well thought out processes. This article will outline these essential steps that agencies need to complete before conducting HIV prevention interventions/activities. Accomplishing these steps may appear to be a linear process, but it is actually a circular process. Each step is connected, builds upon, and reinforces the other. *The steps for formulating HIV prevention activities are necessary if using a science based or non science based intervention.* To ensure an intervention is viable and to demonstrate it was successful, an agency must complete the necessary steps.

Community Planning

The foundation of any HIV prevention effort is **community planning**. First, an epidemiologist uses state and/or local data to identify populations at high risk of acquiring HIV. Then the CPG (Community Planning Group) produces a community services assessment (needs assessment, gap analysis, community resource inventory), prioritizes/ranks these populations, and identifies evidence-based/scientific-based interventions to reach their prioritized populations. Once the CPG has completed these difficult tasks, the regional AIDSNET (AIDS Service Network) office is responsible for funding agencies (in a fair and impartial manner) to conduct interventions that will assist these populations to reduce their high-risk behavior. Agencies receiving funds face the challenging task of reaching these populations and assisting them to reduce their chances of acquiring or transmitting HIV by changing their risky behavior.

Formative Evaluation

Building on the tasks completed by the CPG, agencies must conduct a **formative evaluation**. This is a series of activities, which involve contact with community members. Involving community leaders and gatekeepers can mean the success or demise of any prevention efforts attempted; they can be a valuable ally or a formidable adversary in HIV prevention efforts. The community leaders and gatekeepers will be very helpful in reaching prioritized populations with the ultimate goal of preventing the spread of HIV. Using the input gathered, agencies are ready to investigate an available evidence-based/scientific-based intervention or develop an appropriate intervention for the designated population. Designing a "home grown" intervention requires basing the intervention on a proven theory or model. The desired population must be involved in planning, implementing, and evaluating any intervention.

Whether an agency decides to replicate one of the interventions identified by the CPG, use another scientific-based intervention, or formulate their own theory or model based intervention, involving stakeholders through focus groups and/or key informant interviews must occur. These activities will assist in determining if an intervention is feasible and appropriate for the population and community. They will also provide valuable information concerning how an intervention should be conducted. During this process, the initial adapting or tailoring of a previously evaluated intervention should occur. The core elements of the original intervention **must** remain unchanged. The intervention's key characteristics can and should be tailored to fit the population; however, trying to change the population to fit into an intervention is not a viable option. It is imperative for the prioritized population to be appropriate for the planned intervention.

Evaluability Assessment

During the formative evaluation, an agency needs to conduct a four-stage **evaluability assessment of the intervention**, which includes determining the method that will be used to evaluate the intervention. The four stages are: 1- Intervention logic model; 2- Process monitoring and process evaluation; 3- Outcome monitoring; and, 4- Selection of evaluation tool.

Stage 1: Is the intervention clearly described? Interventions should be written in a logic model format. Logic models portray the sequence of events that will lead to a successful outcome and may be displayed as a flow chart or a circular model. A logic model must contain the following:

✓ **Problem Statement:** The problem statement should be evidence-based, explain underlying causes for HIV risk, contain sufficient detail to be self-explanatory, and be based on a comprehensive needs assessment.

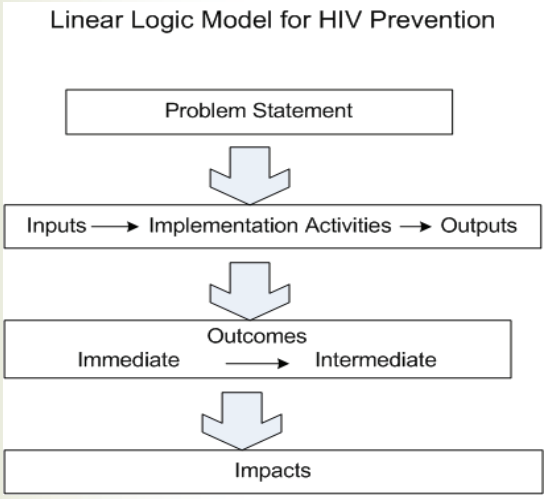
✓ **Implementation:** Outline the items essential to the implementation of an intervention.

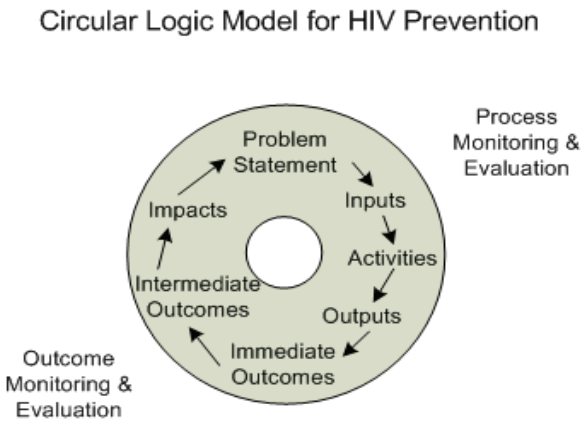
- *Inputs* –the resources used in an intervention (money, staff, curricula, and materials).
- *Activities –the services an intervention provides to accomplish* the objectives (outreach, material distribution, counseling sessions, workshops, and training). It is imperative for the intervention's core elements to appear here.
- *Outputs* –the direct products/deliverables of the intervention (intervention sessions completed, people reached, and materials distributed).

✓ **Outcomes:** These are the expectations of the intervention.

- *Immediate Outcomes* – immediate results of the intervention (changes in attitudes, beliefs, and skills).
- *Intermediate Outcomes* – these are the results that occur some time after the intervention is completed (changes in behaviors, skills, policies, and environment).

✓ **Impacts:** These are the long-term results of one or more interventions over time, such as changes in HIV infection, morbidity, and mortality.





A logic model will**:**

- Include a problem statement, inputs, activities, outcomes, immediate and intermediate outcomes, and impacts;
- Include outcomes responsive to the issues identified in the problem statement;
- State outcomes as changes in knowledge, attitudes, beliefs, intentions, skills, behaviors, access, policies or environmental conditions;
- Distinguish between immediate and intermediate outcomes;

- Include outcomes that are realistic for the stated activities;
- State outcomes that are within the scope of the intervention's influence;
- Reflect agreement among major stakeholders about intended implementation and outcomes; and
- Illustrate clear, sequential, and logical linkages between each part of the logic model.

To assist in understanding a logic model and to illustrate how one should be written, a completed logic model is provided below. Injection drug users have been identified as the prioritized population.

Problem Statement: Although some IDUs are using the syringe exchange, information gathered from a prioritized population needs assessment (conducted at the syringe exchange) revealed there is a large quantity of secondary exchange happening in the community. There is a low self-efficacy for condom use with main and/or casual sexual partner(s). There is also low self-efficacy to refuse sharing needles with their main and/or casual drug using partner(s). Skills for negotiating condom use, proper use of drug injecting equipment (cotton, cooker, needles, syringes, rinse water), and overall knowledge of HIV facts are not known.

IMPLEMENTATION

INPUTS	ACTIVITIES	OUTPUTS
• Project Funding • Outreach Staff • Stay Clean Curriculum • Safer sex kits • Pamphlets/brochures	• Recruit IDUs from the needle exchange to participate in a group level intervention. • Provide 4 skill building and harm reduction sessions (90 minutes each) including, but not limited to condom negotiation skills, injection harm reduction, and HIV education (focus will be on what is known and not known). • Provide CTR services to participants after the 1st session. • Provide incentives at the end of each session ($10).	• Recruit 120 IDUs for the 4 groups (4 sessions each). • Conduct 4 groups with a completion rate of 90%. • Provide 480 safe sex kits. • Provide at least 70 clients with CTR services and referrals to other appropriate agencies. • Provide Incentives to 120 clients.

OUTCOMES

IMMEDIATE OUTCOMES	INTERMEDIATE OUTCOMES
• Knowledge of HIV transmission and prevention will increase. • Intention to access specific referrals will increase (client centered). • Knowledge of personal HIV status (through C&T) will increase. • Intention to not share drug injecting equipment (including cotton, cooker etc.) will increase. • Intention to use condoms with main and non-main partners will increase. • Intention to discuss HIV status with current and future sex/ needle partners will increase.	• Norms & attitudes among the IDU community will change to support safer injecting and sex practices. • Referral follow through will increase (went to 1st appointment). • Participants will participate in both pre and post counseling. • Sharing drug-injecting equipment (including syringe, cooker, cotton, etc) will decrease. • Condom use will increase among IDUs with main and casual sex partner(s).

PROCESSES MONITORING

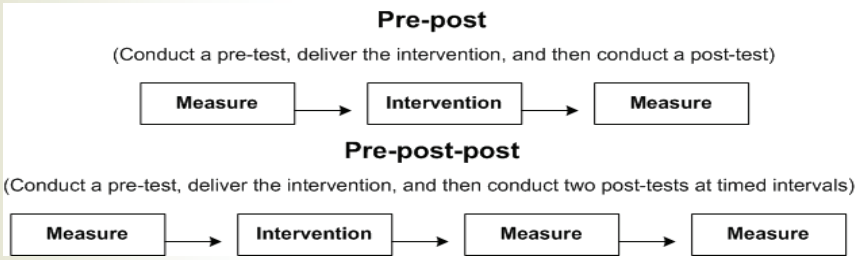
Stage 2: Is the intervention implemented as intended? In state 2, **t**he fidelity of the intervention will be reviewed and evaluated. Selecting the appropriate method to evaluate an intervention enables agencies to validate the desired outcome was accomplished. To complete the **process-monitoring** step, a mechanism is needed to determine: the characteristics of the population served, the services provided, and the resources used to deliver the services. An intervention participant's sign-in sheet or other data collection system and observation of delivery, by the supervisor, will function as such a mechanism.

PROCESS EVALUATION

There are a number of items to review in order to complete the **process evaluation** step; agencies are really checking the fidelity of the intervention. The items reviewed are: population served, dosage, intervention content, consistency of delivery across staff (observation by supervisor), and consistency of delivery over time, venue, and time delivered. This data will tell the agency if the intervention was implemented as intended, reached those intended, and what barriers clients experienced accessing the intervention. Areas where this information may be retrieved are: sign in sheets that collect data on risk, demographics, and service utilization; outreach contact records; case management records, checklist used during service delivery observation, interviews or focus groups with staff and clients, surveys and questionnaires with staff and clients, and records of staff training.

OUTCOME MONITORING

Stage 3: How will outcomes be measured? There are several ways **outcome monitoring** can be accomplished. This process will let you know if conducting the intervention achieved the desired outcome. A few ways to conduct outcome monitoring are:

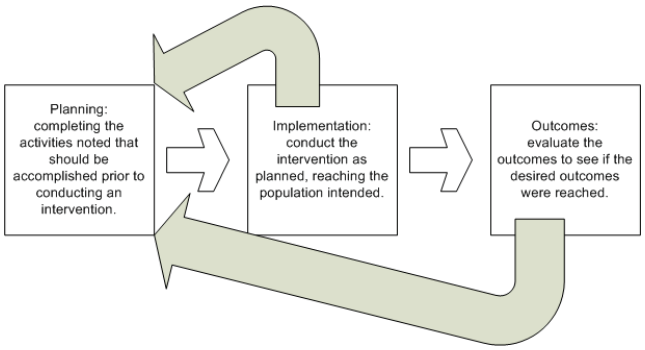


All of the steps provide natural connections to one another. The following tables demonstrate the connections.

RELATIONSHIP BETWEEN PLANNING, IMPLEMENTATION, AND OUTCOMES

If the implementation phase of an intervention is not going well, agencies should return to the planning phase and review the plan.

If the intervention did not produce the desired outcomes, agencies should return to the planning phase and review the plan.



USING PROCESS EVALUATION AND OUTCOME MONITORING TO IMPROVE INTERVENTIONS

Outcome Monitoring: Did the desired outcomes occur?	Process Evaluation: was the intervention implemented as intended? YES	Process Evaluation: was the intervention implemented as intended? NO
YES	• Consider conducting outcome evaluation to determine if the intervention caused the outcomes.	• Consider implementing the intervention as intended and monitoring outcomes. • Consider repeating what was actually implemented and monitoring outcomes.
NO	• Red Flag! Consider redesigning the intervention.	• Consider implementing the intervention as intended.

To adequately evaluate your intervention, the desired outcome objectives must be written in evaluable terms. Using a completed logic model, an agency will find writing outcome objectives a relatively simple process. Outcome objectives should be written in the "**SMART**" framework.

Specific: does the objective clearly specify what will be accomplished and by how much?

Measurable: is the objective measurable?

Appropriate: does the objective make sense in terms of what the intervention is trying to accomplish?

Realistic: is the objective achievable given available resources and experience?

Time-based: does the objective specify when it will be achieved?

The following table uses the logic model written for the IDU population and provides: measurable outcomes, measures of success, and where this information can be obtained.

LOGIC MODEL OUTCOME	SMART OUTCOMES	MEASURES OF SUCCESS	DATA SOURCE
Condom use will increase among IDUs with main and casual sex partner(s).	By December 31, 2006, increase from 10% to 40% the number of clients who use condoms with main and casual sex partner(s).	The number of clients who self-report using condoms with all sexual partners will increase.	Questionnaire, survey, and post intervention individual risk assessment.
Sharing drug injection equipment (including syringe, cooker, cotton, etc) with main and casual injection partner(s) will decrease.	By December 31, 2006, decrease from 50% to 20% the frequency of clients sharing drug-injection equipment with main and casual injection partner(s).	The number of clients who self-report a decrease in sharing drug-injecting equipment will increase.	Post intervention individual risk assessment.
Norms & attitudes among the IDU community will change to support safer injection and sex practices.	By December 31, 2006, increase from 30% to 60% the number of IDUs who practice safer sex and injection activities.	The number of clients changing from risky to safer sex and injecting practices will increase.	Survey, questionnaire, and client interviews.
Referral follow through will increase (went to 1st appointment).	By December 31, 2006, increase from 15% to 40% the number of clients who attend the first appointment to any referred service.	The number of clients who follow through with referral appointments will increase.	Client journals and client based tracking system.

Stage 4: What evaluation design will be used? An agency must decide the rationale and tools they plan to use for evaluation. During stage 2, useful evaluation mechanisms were discussed. Choosing an appropriate tool to demonstrate effectiveness of the intervention is of the utmost importance.

Once an agency has successfully completed formative evaluation, process monitoring, process evaluation, and outcome monitoring, they are ready to test pilot the intervention. Completing the pilot with a small segment of the prioritized population will provide valuable information needed prior to conducting the intervention for the full population. The individuals participating in the pilot should be members of the population and should not have been involved in any of the intervention planning steps to this point; using non-involved participants will ensure the outcome achieved is accurate and not attributed to participants knowing the desired outcome. This will let an agency know if all the work accomplished so far will produce the desired outcome.

The activities conducted after the pilot test are essentially the same activities which were conducted prior to the test, namely: engaging the stakeholders in the process, determining what services were delivered to whom, determining whether the intervention was implemented as intended, and determining if the intervention achieved the outcome objectives. This is the next appropriate place to think about and adapt and/or tailor the intervention prior to implementation for the full prioritized population. Monitoring and evaluating an intervention is an ongoing process of HIV prevention. It is important to know intervention activities are conducted as intended and the desired outcome is achieved.

This article presented the essential steps in planning, implementing, and evaluating an appropriate intervention. Does this guarantee an intervention will be successful? No it does not, however it does steer an agency in the appropriate direction to reach prioritized populations with effective interventions. The valuable evaluation steps provided will make it easier for any agency to see what is working well and what may need to be changed. The information contained in the article is from the "*Monitoring and Evaluation Outcomes to Improve HIV Prevention Interventions*" training, conducted at CDC in 2003.

If you have questions or concerns, please feel free to contact me via email at **frank.hayes@doh.wa.gov** or (360) 236-3486.

Client Services

What's EIP?

The Washington State Department of Health's Client Services **Early Intervention Program** (EIP) helps eligible persons with HIV to get the health care they need to improve and maintain their health.

After applying for and becoming eligible for EIP services, clients may receive the following service depending on their circumstances:

Prescription Medications On EIP Formulary - EIP can pay for medicines on our formulary or if you have insurance, pay your co-pays for medicines to treat HIV and many related conditions.

Limited HIV Medical Visits And Tests - EIP pays for HIV related medical visits and tests when eligible clients see an EIP contracted medical provider. If you have insurance, EIP may pay your deductibles and cover you during a pre-existing period when you see an EIP contracted medical provider.

Insurance Premium Payment Assistance - EIP eligible clients may be able to get health insurance and help paying premiums.

Spend down Assistance - EIP can pay DSHS Medicaid spend down up to $900 per month.

WHAT ARE EIP'S ELIGIBILITY REQUIREMENTS?

✓ Have HIV

✓ Live in Washington State

✓ Have a gross monthly income of $ 2,393 or less for a single person. Clients enrolled in EIP prior to September 1, 2002 may have incomes up to $2,951.

✓ Have resources of $10,000 or less-not counting one home, one car and certain retirement funds.

HOW CAN I FIND OUT MORE ABOUT EIP?

Go to the Client Services website to view or print EIP information and an application at:

http://www.doh.wa.gov/cfh/HIV_AIDS/Client_Svcs/EarlyInterventionProgram.htm

or go to www.doh.wa.gov/cfh/hiv.htm, click on Client Services, on the left hand column click on Early Intervention Program. At that site in the left hand column you can select an English or Spanish EIP application.

For general EIP information you can call Teri Eyster Hintz at (360) 236-3449. For individualized information you can call the EIP toll free number at 1-877-376-9316 and ask to speak to an EIP Client Services Representative. For clients whose last name begins with the letters:

A-B or G-O	Lori Miller	(360) 236-3493
C-F or P-Z	Robin Vaughn	(360) 236-3435

Ryan White Title II Funding

As a result of a grant application submitted in January 2005 to the HIV/AIDS Bureau of Health Resources and Services Administration (HRSA), DOH will receive $11,198,763 in Ryan White Title II funds to provide services to persons living with HIV/AIDS and their families. The funds reflect an increase of $307,352 for the Early Intervention Program, but a decrease of $234,244 in dollars that fund HIV supportive services. Ryan White care consortia throughout the state will be tasked with determining how to incorporate these reductions into their overall delivery of services for Fiscal Year 2005, which begins April 1.

The STD Focus

BY BONNIE NICKLE; DOH STD EDUCATIONAL RESOURCE COORDINATOR

Seattle STD Course for Non-Clinicians and The STD-HIV Connection

Seattle's STD/HIV Prevention Training Center's STD course for outreach workers is first rate and priced right. Many of you have asked for affordable training. Clinicians have asked that there be training with an emphasis on asymptomatic infection. The good news is that all we've ever asked for is available (with no charge for tuition). The bad news is that these one-day courses are booked until December 8th.

According to Amy Radford (**aradford@u.washington.edu,** (206) 616-7516), the Seattle course coordinator and lecturer, about 18 people can register at one time. As soon as word got out, the registrations zoomed. No harm in calling NOW to assure a spot for later this year.

California also has a training center and their staff developed the very easy-to-read but detailed book for the course. WSR is grateful to their staff and especially to Linda DeSantis for permission to excerpt and adapt the following material on the interaction of STDs and HIV from the course outline:

WHAT IS THE STD- HIV CONNECTION?

- The sexual behaviors that put one at risk for HIV also put one at risk for many other STDs.
- STD infections increase the chance for *transmission of* and *infection by*

  HIV:

  * Syphilis or herpes sores or lesions provide easy entry for HIV into the body.
  * Syphilis or herpes sores or lesions provide easy exit for HIV from the body;
  * STD infections greatly increase the amount of HIV in sexual fluids. (For example, HIV viral load can be 8 times higher with gonorrhea.)
  * STD infections greatly increase the number of white blood cells at the site of infection, thereby increasing the number of target cells for HIV to infect.
- Certain STD infections may accelerate (speed up) the progression of HIV disease.
- Underlying HIV infection may *alter* the symptoms, complications and disease progression of STDs such as herpes, syphilis or hepatitis C.
- Preliminary population-based studies in Tanzania, Africa suggest that controlling STDs may lower the incidence of HIV.

STDs AND HIV: WHAT ARE THE DIFFERENCES?

- Some STDs can be passed by direct lesion (sore) to skin or lesion to mucous membrane contact with no blood, semen or vaginal secretions involved.

- Some STDs are *relatively easy* to transmit by oral sex, whereas HIV is not easily transmitted this way.
- Though no research has proved it, some clinicians think that it *may* be possible that STD infections in the throat or mouth may increase the chances for HIV infection via this route.
- Most STDs are much more sexually infectious than is HIV for any sexual route of infection.
- STDs are much more common than HIV

STDs INCREASE THE CHANCES FOR HIV INFECTION

- STDs increase (↑) the risk of acquiring HIV:

Chlamydia	↑ risk 3 -- 5 times
Genital herpes	↑ risk 3 -- 6 times
Gonorrhea	↑ risk 3 -- 5 times
Syphilis	↑ risk 3 -- 4 times
Trichomoniasis	↑ risk 2 -- 4 times

Selected Readings

How to Read the References

Author(s), "Title," *Journal Name*, Date or Year; Volume (Number): Pages.

Key:

* Popular Reading

** Moderate Difficulty; Some Understanding Of Medical Terms

*** Medical Background Needed

**** Technical Reading.

Hepatitis

** *MMWR* "Acute Hepatitis B Among Children and Adolescents – United States, 1990-2002." November 5, 2004;53(43):1015-1018. Since implementation of child immunization, the incidence of reported cases has dropped from 3.03 per 100,000 in 1990 to 0.34 in 2002, representing a decline of 89%.

*** Poland G.A. and Jacobson R.M. "Prevention of Hepatitis B with the Hepatitis B Vaccine." *New England Journal of Medicine* December 30, 2004;351(27):2832-2838.

**** Lu C-Y., Chiang B-L., Chi W-K., and others. "Waning Immunity to Plasma-Derived Hepatitis B Vaccine and the Need for Boosters 15 Years After Neonatal Vaccination." *Hepatology.* December 2004;40(6):1415-1420.

*** Choi K-H., McFarland W., Neilands T.V., and others. "High Level of Hepatitis B infection and Ongoing Risk Among Asian/Pacific Islander Men Who Have Sex With Men, San Francisco 2000-2001." *Sexually Transmitted Diseases.* January 2005;32(1):44-48.

*** Dominitz J., Boyko E.J. Koespell T.J. and others. "Elevated Prevalence of Hepatitis C Infection in Users of United States Veterans Medical Centers." *Hepatology.* January 2005;41(1):88-96. In this University of Washington study, the subjects exceeded the estimate from the general U.S. population by more than 2-fold. Among those testing positive for HCV, 78% either had a transfusion or had used injection drugs.

*** Dalgard O., Bjøro K. Hellum K.B. and others. "Treatment with Pegylated Interferon and Ribavarin in HCV Infection with Genotype 2 or 3 for 14 Weeks: A Pilot Study." *Hepatology.* December 2004;40(6):1260-1265. Sustained response, measured at 24 weeks, was more common in patients with genotype 3a in this very preliminary trial of shorter treatment.

**** Bogdanos D-P., Mieli-Vergani G. and Dergani D. "Non-Organ-Specific Autoantibodies In Hepatitis C Virus Infection: Do They Matter?" *Clinical Infectious Diseases.* February 15, 2005;40(4):508-507. Clear explanation of current research on NOSAs and biochemical evidence of liver disease.

**** Lascar R.M., Lopes A.R., Gilson R.G. and others. "Effect of HIV Infection and Antiretroviral Therapy on Hepatitis B Virus (HBV)-Specific T Cell Responses in Patients Who Have Resolved HBV Infection." *Journal of Infectious Diseases.* April 1, 2005;191(7){1169-1179.

** Kaye S. "No Observed Effect of GB Virus C Coinfection on Disease Progression in a Cohort of African Women Infected with HIV-2 or HIV-2." *Clinical Infectious Diseases.* March 15, 2005;40(6):876-878. Study results did not confirm previous findings of slower disease progression associated with GBV-C.

*** Oberdorfer A., Wiggers J.H., Bowman J. and others. " Monitoring and Educational Feedback to Improve the Compliance of Tattooists and Body Piercers with Infection Control Standards: A Randomized Controlled Trial." *American Journal of Infection Control.* May 2004;32(3):147-154. In this Australian study no effects were found in terms of improving knowledge, but in the experimental group there was an increase in the perceived risk of being detected and penalized for non-compliance.

FAMILY PLANNING

** "Extra Protection." *Consumer Reports.* February 2005:34-38. Evaluation of condom brands and contraceptive methods from a leading non-profit consumer group.

*** Raine T.R., Harper C.C. and Rocca C.H. "Direct Access to Emergency Contraception Through Pharmacies and Effect on Unintended Pregnancy and STIs." *JAMA.* January 5, 2005;293(1):54-62. Easier access to EC did not compromise regular contraceptive use or lead to an increase in risky sexual behaviors.

*** Litt I.F. "Placing Emergency Contraception in the Hands of Women." *JAMA.* January 5, 2005;293(1):98-99.

** "Pharmacists and Emergency Contraception." *New England Journal of Medicine.* March 3,2005;352(9):942-944. Letters to the editor.

**** Koshiol J.E., St .Laurent S.A. and Pimenta J.M. "Rate and Predictors of New Genital Warts Claims and Genital Warts-Related Healthcare Utilization Among Privately Insured Patients in the United States." *Sexually Transmitted Diseases.* December 2004;31(12):748-752. Rates were higher for men than women, but higher in 15-29-year old women than men.

*** Ackermann S. and Beckmann M.W. "Accuracy of Cervical Cancer Staging Needs Improvement." (*Letter) American Journal of Obstetrics and Gynecology.* February 2005;192(2):659-660. Ongoing arguments about changing staging to include histopathologic and other assessments.

*** Jones R.K., Purcell A. and Singh S. "Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception." *JAMA* January 19, 2005;293(3):340-348.

*** Manlove J., Ryan S and Franzetta K. "Contraceptive Use and Consistency in U.S. Teenagers' Most Recent Sexual Relationships." *Perspectives on Sexual and Reproductive Health.* November/December 2004;36(6): 265-275. Strategies to prevent unintended pregnancy.

**** Frey K.A. and Patel K.S. "Initial Evaluation and Management of Infertility by the Primary Care Physician." *Mayo Clinic Proceedings.* November 2004;79(11):1439-1443.

*** Brown Z. "Managing Herpes in Pregnancy." *The Helper.* 2004 Winter Issue. 1, 3-5. Interview with UW herpes expert, Dr. Zane Brown.

** Zimet G.D., Mays R.M., Strurm L.A. and others. "Parental Attitudes About Sexually Transmitted Infection Vaccination for Their Adolescent Children." *Archives of Pediatrics and Adolescent Medicine.* February 2005;159:132-137.

*** McMullin J.M., De Alba I., Chávez L.R. and Hubbell F.A. "Influence of Beliefs About Cervical Cancer Etiology On Pap Smear Use Among Latina Immigrants." *Ethnicity and Health. 2005;10(1):3-18.* Culturally related beliefs play a role in the decision to obtain a pap test. Education on HPV transmission and screening in the absence of symptoms is important.

HIV/AIDS

**** Rabaud C., Burty C. Grandidier M. and others. "Tolerability of Post-exposure Prophylaxis with the Combination of Zidovudine-Lamivudine and Lopinavir-Ritonavir for HIV Infection." *Clinical Infectious Diseases.* January 15,2005;40(2):303-305. Fifty nine percent experienced adverse side effects which led to premature PEP discontinuation in 20% of participants. The authors call for head-to-head studies with other drug combinations.

**** Benson C.A., Kaplan J.E., Masur H., Pau A. and Holmes K.K. "Treating Opportunistic Infections among HIV-Infected Adults and Adolescents: Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America." *Clinical Infectious Diseases.* March 15, 2005;140, Supplement 3. Entire Issue.

*** Golden M. R., Hogven M. and Potterat J.J. "HIV Partner Notification in the United States: A National Survey of Program Coverage and Outcomes." *Sexually Transmitted Diseases."* December 2004;313(12):709-712.

** Denning P.H. and Campsmith M.L. "Unprotected Anal Intercourse Among HIV-Positive Men Who Have a Steady Male Sex Partner With Negative or Unknown HIV Serostatus." *American Journal of Public Health.* January 2005;95(1):152-158. Even after learning of their infection, one fifth of HIV+ MSM who had a single steady male partner with negative or unknown serostatus engaged in UAI, underscoring the need to expand HIV prevention among these men.

*** Bogart L.M. and Bird T. S. "Exploring the Relationship of Conspiracy Beliefs About HIV/AIDS to Sexual Behaviors and Attitudes Among African-American Adults." *Journal of the National Medical Association.* November 2003;95(11):1057-1065.

*** Bogart L.M. and Bird T.S. "Are HIV/AIDS Conspiracy Beliefs a Barrier to HIV Prevention Among African Americans?" *Journal of Acquired Immune Deficiency Syndromes.* February 1, 2005;38(2):213-218. Analysis of telephone survey results of 500 African Americans led the authors to conclude that conspiracy beliefs are a barrier to HIV prevention.

** "Clearing the Myths of Time: Tuskegee Revisited." *The Lancet Infectious Diseases.* March 2005;5:127. The effect of the Tuskegee study on the disengagement of many black Americans with the reality of the AIDS epidemic.

*** Bozzette S.A. "Routine Screening for HIV Infection---Timely and Cost Effective." *New England Journal of Medicine.* (Editorial) February 10, 2005;352(6):620-621.

** Markowitz M., Mahri H., Mehandru S. and others. "Infection with Multidrug Resistant, Dual-Tropic HIV-1 and Rapid Progression to AIDS: A Case Report." *Lancet.* March 19, 2005;365:1031-1038. This article addresses early lab reports and progression to symptomatic AIDS in 4-20 months of a recently infected person from New York. This case received a great deal of media attention.

**** Aramzabal L., Casado J.L., Moya J. and others. "Influence of Liver Fibrosis on Highly Antiretroviral Therapy --- Associated Hepatotoxicity in Patients with HIV and Hepatitis C Virus Co-Infection." *Clinical Infectious Diseases.* February 15, 2005;40(4): 588-593. HAART-associated hepatotoxicity correlated with liver histological stage. There was no difference in risk for different antiretroviral therapies in patients with mild to moderate fibrosis in this prospective study of 107 patients.

*** Bogart L.M., Kral A.H. and Scott A. "Sexual Risk Among Injection Drug Users Recruited From Syringe Exchange Programs in California." *Sexually Transmitted Diseases.* January 2005;32(1):27-34. Includes data on anal sex among heterosexuals, reported condom use for various behaviors and current drug preferences.

*** Haley N., Roy E. and Leclerc P. "HIV Risk Profile of Male Street Youth Involved in Survival Sex." *Sexually Transmitted Infections.* December 1, 2004;890(6):526-530.

** Moore J.P. "Topical Microbicides Become Topical." *New England Journal of Medicine.* January 20, 2005;352(3):298-300. Hope and hype.

*** Watts D.H., Fazarri M., Minkoff H., Hillier S.L. and others. "Effects of Bacterial Vaginosis and Other Genital Infections on the Natural History of Human Papillomavirus Infection in HIV-1-Infected and High-Risk HIV-1-Uninfected Women." *Journal of Infectious Diseases.* April 1, 2005;191(7):1129-1139.

*** MMWR "Antiretroviral Post-exposure Prophylaxis After Sexual, Injection-Drug Use, or Other Non-occupational Exposure to HIV in the United States." January 21, 2005;54(RR02):1-20. This report summarizes knowledge about the use and potential efficacy of non-occupational post-exposure prophylaxis and details guidelines for its use in the United States. Accumulated data from animal and human clinical and observational studies demonstrate that antiretroviral therapy initiated as soon as possible within 48-72 hours of sexual, injection-drug-use, and other substantial non-occupational HIV exposure and continued for 28 days might reduce the likelihood of transmission.

Press release at: http://www.cdc.gov/od/oc/media/pressrel/r050120.htm.

Text version - http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm

PDF version - http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf

*** Kurth A.E., Martin D.P., Golden M.R. and others. "A Comparison Between Audio Computer-Assisted Self-Interviews and Clinician Interviews for Obtaining the Sexual History." *Sexually Transmitted Diseases.* December 2004;31(12):719-726. The computer was acceptable to 89% of this Seattle STD clinic population where women more often reported more same sex behavior, transactional sex, and amphetamine use, but fewer symptoms when using ACASI.

STD

*** Bolan B, Amezola P., Kerndt P. and others. "Inadvertent Use of Bicillin® C-R to Treat Syphilis Infection --- Los Angeles, California 1999—2004. *MMWR.* March 11, 2005;54(09):217-219. Despite a change in package color in 2002 to distinguish Bicillin C-R, the wrong drug, from Bicillin L-A, the correct drug, and a package insert warning against the use of C-R to treat syphilis, the proprietary names and package appearance remained similar and the wrong medication was given. Inadvertent use occurred in several other STD programs during 1993—1998. Clinicians: refer to the CDC's 2002 treatment guidelines, http://www.cdc.gov/STD/treatment/2-2002TG.htm#Syphilis and double check syphilis medications.

** Park M.A. and Li J.T.C. "Diagnosis and Management of Penicillin Allergy." *Mayo Clinic Proceedings.* March 2005;80(3):405-411. Among patients with a reported history of PCN allergy, 80% to 90% have no evidence of IgE antibodies to PCN on skin testing. This article presents a clinical scenario, patient history, skin testing and in vitro assays.

*** Golden M.R., Whittington W.L.H., Handsfield H.J. and others. "Effect of Expedited Treatment of Sex Partners on Recurrent or Persistent Gonorrhea or Chlamydial Infection." *New England Journal of Medicine.* February 17, 2005;352(5):676-685. Expedited treatment of partners reduced the rates of GC or CT in this UW and CDC study.

** Hogben M., McCree D.H. and Golden M.R. "Patient-Delivered Therapy for Sexually Transmitted Diseases." *Sexually Transmitted Diseases.* February 2005;32(2):101-105. About half of U.S. physicians have ever given STD-infected patients medications for their partners, and 1 in 7 do so frequently.

**** Dessi D., Gelogu G., Emonte E. and others. " Long-term Survival and Intracellular Replication of *Mycoplasma hominis* in *Trichomonas vaginalis* Cells: Potential Role of the Protozoon in Transmitting Bacterial Infection." *Infections and Immunity.* February 2005;73(2):1180-1186. Exploration of the possibility of a symbiotic relationship.

*** Eley A., Pacey A.A. and Galdiero M. "Can *Chlamydia trachomatis* Directly Damage Your Sperm?" *Lancet Infectious Diseases.* January 1, 2005(1); Review and hypothetical model for pursuing this research.

** Sherrard J., Rings M. and Hall C. "Where Has All The Chlamydia Come From? The Clinical Impact Of The Introduction Of An Improved Chlamydia Test." *International Journal of STD and AIDS*. February 2005;16:163-165. Rates doubled at one clinic with the introduction of the NAATS test.

*** Kohl, K.S., Sternberg M.R., Markowitz L.E., and others. "Screening of Males for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* Infections at STD Clinics in Three U.S. Cities --- Indianapolis, New Orleans, and Seattle." *International Journal of STD and AIDS*. December 2004;15(12): 822.828. Men with asymptomatic infections can serve as a reservoir of infections. Transmission of GC to female partners was estimated to be 73%, CT 65%-68%.

*** Fiscus L.C., Ford C.A. and Miller W.C. "Infrequency of Sexually Transmitted Disease Screening Among Sexually Experienced U.S. Female Adolescents." P*erspectives on Sexual and Reproductive Health.* November/December 2004;39(6):233-238 and online at http://www.agi-usa.org/journals/toc/psrh3606toc.html.

*** Winer R.L., Kiviat N.B., Hughes J.P. and others. "Development and Duration of Human Papillomavirus Lesions, after Initial Infection." *Journal of Infectious Diseases.* March 1, 2005;191:731-738. Analysis was for types 6, 11,16, 18, 31, 45, and 56 clearance rates and detection given frequency of screening.

**** Bearman P.S., Moody J. and Stovel K. "Chains of Affection: The Structure of Adolescent Romantic and Sexual Networks." *American Journal of Sociology.* July 2004;110(1):44-91. The mapping of 288 one-to-one sexual relationships in a mid-sized Midwestern town led the researchers to conclude that mass education rather than a focus on STD "core" transmitters is needed.

*** Valappil T., Kelaghan J., Macaluso M., and others. "Female Condom and Male Condom Failure Among Women at High Risk of Sexually Transmitted Diseases. *Sexually Transmitted Diseases.* January 2005;32(1):35-43. Experience determines success with either condom.

** Tomnay J.E., Pitts M.K. and Fairley C.K. "New Technology and Partner Notification – Why Aren't We Using Them?" *International Journal of STD and AIDS*. January 2005;16:19-22. Ethical and technical considerations.

** Ross J.J. "Shakespeare's Chancre: Did the Bard Have Syphilis?" *Clinical Infectious Diseases.* February 1,2005;40(3):399-404. Sure to get students to check out Elizabethan literature. Florid and fun. Impressive references.

TUBERCULOSIS

**** Sambandamurthy V.K., Derrick S.C., Jalapathy K.V. and others. "Long-Term Protection against Tuberculosis Following Vaccination with a Severely Attenuated Double Lysine and Pantothenate Auxotroph of *Mycobacterium tuberculosis." Infection and Immunity.* February, 2005;73(2):1196-1203. Basic research on a TB vaccine for those who are CD4-deficient.

*** Rubin E.J. "Toward a New Therapy for Tuberculosis." *New England Journal of Medicine.* 352(9):March 3, 2005:933-934. Describes very preliminary work on a new antibiotic that may be useful for TB, including resistant strains of TB.

**** LoBue P.A. and Moser K.S. "Screening of Immigrants and Refugees for Pulmonary Tuberculosis in Dan Diego County, California." *Chest.* December 2004;126:1777-1782.

** Division of Tuberculosis Elimination, National Center for HIV, STD and TB Prevention, CDC. "Trends in Tuberculosis --- United States, 2004." *MMWR.* March 18, 2005;54(10):245-249. During 2004 14,511 confirmed TB cases were reported in the US.

**** Malakmadze N., González I.M., Oemig T. and others. "Unsuspected Recent Transmission of Tuberculosis among High-Risk Groups: Implications of Universal Tuberculosis Genotyping in Its Detection." *Clinical Infectious Diseases.* February 1, 2005;40(3):366-373. The advantages of genotyping and intensive epidemiological methods.

** Gany F.M., Trinh-Shevrin C. and Changrani J. "Drive-by Readings: A Creative Strategy for Tuberculosis Control Among Immigrants." *American Journal of Public Health.* January 2005;95(1):117-119.

**** Vidal C.G., Fernández S.R., Lacasa J.M., and others. "Paradoxical Response to Antituberculosis Therapy in Infliximab-Treated Patients with Disseminated Tuberculosis." *Clinical Infectious Diseases.* March 1, 2005;40(5):756-759.

**** Clarke P., Glick S. and Reilly B.M. "On The Threshold---A Diagnosis of Exclusion." *New England Journal of Medicine.* March 3, 2005;325(9):919-924. A clinical problem-solving exercise for a patient with fever and aphasia.

* "Tuberculosis Outbreak Among Staff in Correctional Facilities, Florida 2001-2004: Lessons Re-learned." *Infectious Diseases in Corrections Report.* February 2005;8(2):1-9. While many screen for TB, attention to treatment completion can be a problem. Go to: http://www.idcronline.org/ for articles and a free subscription to this Brown University publication. Please bring this article and journal to the attention of law enforcement sites in your community.

*** Naouri B., Virkud V., Malecki J. and others. "Congenital Pulmonary Tuberculosis Associated with Maternal Cerebral Tuberculosis --- Florida, 2002." *MMWR.* March 18, 2005;54(10):249-250. A rare disease with nonspecific signs and symptoms. If untreated, it is fatal.

** Saitz R. "Unhealthy Alcohol Use." *New England Journal of Medicine.* February 10, 2005;352(6):596-607. Many useful charts for students and those new to this topic. Covers screening,, assessments, various interventions, treatments, pharmacotherapy (for withdrawal and other conditions) and pharmacotherapy for coexisting psychiatric conditions.

* Sheff D. "My Addicted Son." *New York Times Magazine.* February 6, 2005. Narrative for students who are not familiar with methamphetamine addiction and the potential for treatment.

** Markos A.R. "Alcohol and Sexual Behavior." *International Journal of STD and AIDS.* February 2005;16:123-127. Review article. Good material for clinical students.

*** Boyer E.W., Shannon M. and Hibberd P.S. "The Internet and Psychoactive Substance Use Among Innovative Drug Users." *Pediatrics.* February 2005;115(2);Part 1, 302-306. A gem for adolescent medicine specialists.

If you do not have access to library services, please call Bonnie Nickle at (360) 236-3498 for single copies of the articles listed.

Other Health Resources

HEPATITIS

On February 8, 2005 the **Food and Drug Administration (FDA) issued a warning** and sent letters to health care providers to communicate an **important drug interaction**. "Drug-induced hepatitis with marked transaminase elevations has been observed in healthy volunteers receiving Rifampin 600 mg once daily in combination with Ritonavir 100 mg/Saquinavir 1000 mg twice daily." You can reach the FDA by phone at 1-800-FDA-1088 or by fax at 1-800-FDA-0178.

HIV

"Antiretroviral Post-exposure Prophylaxis After Sexual, Injection-Drug Use, or Other Non-occupational Exposure to HIV in the United States."-- This report summarizes knowledge about the **use and potential efficacy of non-occupational post-exposure prophylaxis** and details guidelines for its use in the United States. Accumulated data from animal and human clinical and observational studies demonstrate that antiretroviral therapy initiated as soon as possible within 48-72 hours of sexual, injection-drug-use, and other substantial non-occupational HIV exposure and continued for 28 days might reduce the likelihood of transmission.

Text version - http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm

PDF version - http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf

The **Tufts University** site at http://navigator.tufts.edu/health/ has **ratings for nutrition sites** ("Among the Best," " Better Than Most," "Average," and " Not Recommended") including those for food safety and special diets related to HIV infection and liver disease. Health professionals and consumers can find various levels of information – everything from medical grand rounds to elementary reading level handouts.

The **"Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents"** has been revised to include up-to-date drug information, including updated information on nevirapine hepatotoxicity risks, the interaction between rifampin and ritonavir-boosted saquinavir, new pregnancy data for efavirenz, and new contraindications and warnings for ritonavir and lopinavir/ritonavir use. Also included in the updated document is a new table, Table 30, providing information on the tipranavir expanded access program. All changes to the document are highlighted in yellow. The updated guidelines document is available AIDSinfo Web site at: http://www.aidsinfo.nih.gov/guidelines/default_db2.asp?id=50.

STD PREVENTION, FAMILY PLANNING AND REPRODUCTIVE HEALTH

The KidsHealth.org site has a **teen section** including information on navigating a **first pelvic exam** http://www.kidshealth.org/PageManager.jsp?dn=KidsHealth&lic=1&ps=207&cat_id=20015&article_set=20402.

http://www.cdc.gov/cancer/nbccedp/info-cc.htm. **Cervical Cancer and Pap Test Information** from the CDC. The following topics are discussed: why get a pap test, basic facts and risk factors, screening interval recommendations, strategies for reaching underserved populations, and additional links.

CDC's website on men's health has been updated and includes information in four sections: science and research, health and wellness, work and play, family and friends.http://www.cdc.gov/men/.

http://www.mayoclinic.com/programsandtools/morequizzes.cfm features quizzes and informative answers on health and **wellness topics** for men including STD and other infections, immunizations, hepatitis, and alcohol use.

TB

Need a "gee whiz" article on **TB for high school** or non-clinical students? "TB May Have Killed Leprosy" at http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/4244467.stm is just the thing for students who like ancient history with speculative gore. Keep the emphasis on "may" and they are sure to enjoy it.

Other

The National Hispanic Medical Association reminds us that ***Cover the Uninsured Week*** 2005 will take place April 30-May 8, 2005. The defining activity of the 2005 effort will be town hall meetings at which proposals for achieving affordable and stable health care coverage for all Americans will be presented. Visit their web site at: http://www.nhmamd.org/ .

The Harborview Medical Center and the University of Washington's ETHNOMED site at http://healthlinks.washington.edu/ethnomed includes **culture-specific and cross cultural pages** along with a section on **herb-drug interactions**.

http://users.psychoanalysis.net/From%20Journal%20Editors/S007F3465-007FE9B4?WasRead=1 includes a review of "**Transgender Subjectivities: A Clinician's Guide**." edited by Ublado Leli and Jack Drescher, 162 pages, paper $19.95, Binghamton, NY, Haworth Medical Press. These and other transgender issues are also addressed in *The Journal of Gay and Lesbian Psychotherapy,* the official journal of the Association of Gay and Lesbian Psychiatrists, http://www.aglp.org/

http://www.nlm.nih.gov/exhibition/if_you_knew/if_you_knew_01.html is the National Library of Medicine's site for material from an exhibition on the **history of health care provided to Native Americans** by the US government in the 1800's. Along with information on the history of Indian School Hospitals and the Meriam Commission on health care reform, there are biographical sketches of Native American M.D.s including Susan La Flesche Picotte (1865-1915), the first Native American woman M.D. Opinions and reports from Euroamericans of the 1800's are featured.

"**The Health Care of Homeless Persons**: A Manual of Communicable Diseases and Common Problems in Shelters and on the Streets." Edited by James J. O'Connell, 345 pages, $15.00. Boston Health Care for Homeless Program 729 Massachusetts Avenue, Boston MA 02118. Telephone (615) 226-2292.

From Beth Reis at King County's Safe Schools web site comes an invitation to check out "**The Judges' Benchguide on Sexual Orientation and the Law**" This 83-page guidebook was produced by Seattle University Law School for a Gender and Justice Commission on judicial education program in 2004. Go to: http://www.law.seattleu.edu/news/archive/2005/benchguide.pdf

A new **Spanish language brochure** promoting the services of Washington **Tobacco Quit Line** is now available on line at www.quitline.com A print version of the brochure will be available February 14. C*ontact: Juliet Thompson 360-236-3722.*

On February 8, 2005 the Food and Drug Administration (FDA) issued a warning and sent letters to health care providers to communicate an important drug interaction. "Drug-induced hepatitis with marked transaminase elevations has been observed in healthy volunteers receiving Rifampin 600 mg once daily in combination with Ritonavir 100 mg/Saquinavir 1000 mg twice daily." You can reach the FDA by phone at 1-800-FDA-1088 or by fax at 1-800-FDA-0178. Or, search their web site at www.fda.gov/oashi/aids/listserve/archive.html.

TABLE 1. WASHINGTON STATE HIV[1] AND AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, AS OF 03/31/2005

	TOTAL CASES (& CASE FATALITY RATE[2]) DIAGNOSED DURING INTERVAL[3]					DEATHS OCCURRING DURING INTERVAL[4]		CASES PRESUMED LIVING DIAGNOSED DURING INTERVAL[3]		
	HIV[1]		AIDS		**HIV/AIDS**	*HIV[1]*	AIDS	*HIV[1]*	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**Total**	*No.*	No.	*No.*	No.	**Total**
1982	*3*	*(0%)*	1	(100%)	**4**	*0*	0	*3*	0	**3**
1983	*6*	*(17%)*	20	(100%)	**26**	*0*	7	*5*	0	**5**
1984	*13*	*(0%)*	79	(97%)	**92**	*0*	31	*13*	2	**15**
1985	*67*	*(9%)*	132	(97%)	**199**	*0*	81	*61*	4	**65**
1986	*59*	*(14%)*	245	(98%)	**304**	*0*	126	*51*	6	**57**
1987	*74*	*(12%)*	369	(95%)	**443**	*2*	187	*65*	17	**82**
1988	*86*	*(13%)*	493	(94%)	**579**	*6*	236	*75*	32	**107**
1989	*121*	*(12%)*	612	(91%)	**733**	*8*	308	*107*	54	**161**
1990	*141*	*(13%)*	733	(90%)	**874**	*6*	371	*123*	73	**196**
1991	*154*	*(8%)*	835	(86%)	**989**	*4*	461	*142*	117	**259**
1992	*138*	*(8%)*	897	(76%)	**1,035**	*7*	515	*127*	212	**339**
1993	*125*	*(5%)*	944	(67%)	**1,069**	*12*	618	*119*	313	**432**
1994	*175*	*(5%)*	853	(55%)	**1,028**	*5*	664	*166*	385	**551**
1995	*183*	*(3%)*	755	(37%)	**938**	*5*	653	*177*	477	**654**
1996	*225*	*(4%)*	664	(25%)	**889**	*3*	468	*217*	495	**712**
1997	*227*	*(5%)*	509	(19%)	**736**	*7*	221	*216*	412	**628**
1998	*225*	*(2%)*	385	(22%)	**610**	*5*	161	*220*	299	**519**
1999	*278*	*(2%)*	354	(21%)	**632**	*5*	130	*273*	279	**552**
2000	*342*	*(3%)*	431	(19%)	**773**	*29*	155	*333*	350	**683**
2001	*315*	*(1%)*	402	(13%)	**717**	*21*	139	*312*	348	**660**
2002	*311*	*(1%)*	439	(10%)	**750**	*17*	137	*307*	396	**703**
2003	*327*	*(0%)*	435	(7%)	**762**	*13*	157	*326*	406	**732**
2004[5]	*344*	*(0%)*	396	(4%)	**740**	*2*	86	*344*	381	**725**
2005 YTD[5]	41	*(2%)*	37	(3%)	**78**	1	14	40	36	**76**
TOTAL	*3,980*	*(4%)*	11,020	(54%)	**15,000**	*158*	5,926	*3,822*	5,094	**8,916**

TABLE 2. WASHINGTON STATE HIV[1] AND AIDS CASES, GENDER BY AGE AT DIAGNOSIS.

	HIV[1]						AIDS					
	Male		*Female*		*Total*		Male		Female		Total	
	No.	*(%)*	*No.*	*(%)*	*No.*	*(%)*	No.	(%)	No.	(%)	No.	(%)
Under 13	*17*	*(0%)*	*21*	*(1%)*	*38*	*(1%)*	15	(0%)	17	(0%)	32	(0%)
13-19	*65*	*(2%)*	*38*	*(1%)*	*103*	*(3%)*	30	(0%)	11	(0%)	41	(0%)
20-29	*1,117*	*(28%)*	*215*	*(5%)*	*1,332*	*(33%)*	1,626	(15%)	226	(2%)	1,852	(17%)
30-39	*1,412*	*(35%)*	*176*	*(4%)*	*1,588*	*(40%)*	4,651	(42%)	376	(3%)	5,027	(46%)
40-49	*631*	*(16%)*	*93*	*(2%)*	*724*	*(18%)*	2,688	(24%)	220	(2%)	2,908	(26%)
50-59	*146*	*(4%)*	*26*	*(1%)*	*172*	*(4%)*	799	(7%)	89	(1%)	888	(8%)
60+	*18*	*(0%)*	*5*	*(0%)*	*23*	*(1%)*	240	(2%)	32	(0%)	272	(2%)
TOTAL	*3,406*	*(86%)*	*574*	*(14%)*	*3,980*	*(100%)*	10,049	(91%)	971	(9%)	11,020	(100%)

1 Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.

2 Case fatality rate is the proportion of HIV or AIDS patients diagnosed during interval who are known to have died at some time since diagnosis.

3 Year of diagnosis reflects the time at which HIV infection or AIDS was diagnosed by a health care provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

4 Includes deaths among HIV or AIDS patients diagnosed during that interval or any preceding interval.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

IDRH Assessment Unit, P.O. Box 47838, Olympia, WA 98504-7838; (360) 236-3455.

TABLE 3. WASHINGTON STATE HIV[1] CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 03/31/2005

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	2573	(76%)	284	(51%)	14	(36%)	2871	(72%)
Black, not Hispanic	395	(12%)	172	(31%)	15	(38%)	582	(15%)
Hispanic (All Races)	260	(8%)	49	(9%)	6	(15%)	315	(8%)
Asian/Pacific Islander	3	(0%)	4	(1%)	0	(0%)	7	(0%)
Asian	78	(2%)	10	(2%)	4	(10%)	92	(2%)
Hawaiian/Pacific Islander	6	(0%)	1	(0%)	0	(0%)	7	(0%)
Native American/Alaskan	36	(1%)	29	(5%)	0	(0%)	65	(2%)
Multi-race	13	(0%)	1	(0%)	0	(0%)	14	(0%)
Unknown	24	(1%)	3	(1%)	0	(0%)	27	(1%)
Total	3,388	(100%)	553	(100%)	39	(100%)	3,980	(100%)
Exposure Category								
Male/male sex (MSM)	2478	(73%)	N/A	( )	0	(0%)	2478	(62%)
Injecting Drug Use (IDU)	246	(7%)	143	(26%)	0	(0%)	389	(10%)
MSM and IDU	336	(10%)	N/A	( )	0	(0%)	336	(8%)
Transfusion/Transplant	7	(0%)	9	(2%)	0	(0%)	16	(0%)
Hemophilia	12	(0%)	1	(0%)	1	(3%)	14	(0%)
Heterosexual Contact[6]	117	(3%)	275	(50%)	0	(0%)	392	(10%)
Mother at Risk for HIV	0	(0%)	0	(0%)	35	(90%)	35	(1%)
No Identified Risk[7]/Other	192	(6%)	125	(23%)	3	(8%)	320	(8%)
Total	3,388	(100%)	553	(100%)	39	(100%)	3,980	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.
7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.
10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 4. WASHINGTON STATE AIDS CASES, RACE/ETHNICITY[10] AND EXPOSURE CATEGORY, AS OF 03/31/2005

	Adult/Adolescent				Pediatric		Total	
	Male	(%)	Female	(%)	No.	(%)	No.	(%)
Race/Ethnicity[10]								
White, not Hispanic	7997	(80%)	532	(56%)	15	(47%)	8544	(78%)
Black, not Hispanic	955	(10%)	254	(27%)	10	(31%)	1219	(11%)
Hispanic (All Races)	722	(7%)	83	(9%)	4	(13%)	809	(7%)
Asian/Pacific Islander	32	(0%)	13	(1%)	1	(3%)	46	(0%)
Asian	117	(1%)	15	(2%)	0	(0%)	132	(1%)
Hawaiian/Pacific Islander	20	(0%)	6	(1%)	0	(0%)	26	(0%)
Native American/Alaskan	155	(2%)	44	(5%)	1	(3%)	200	(2%)
Multi-race	27	(0%)	5	(1%)	1	(3%)	33	(0%)
Unknown	9	(0%)	2	(0%)	0	(0%)	11	(0%)
Total	10,034	(100%)	954	(100%)	32	(100%)	11,020	(100%)
Exposure Category								
Male/male sex (MSM)	7340	(73%)	N/A	( )	0	(0%)	7340	(67%)
Injecting Drug Use (IDU)	719	(7%)	279	(29%)	0	(0%)	998	(9%)
MSM and IDU	1080	(11%)	N/A	( )	0	(0%)	1080	(10%)
Transfusion/Transplant	72	(1%)	51	(5%)	0	(0%)	123	(1%)
Hemophilia	82	(1%)	4	(0%)	4	(13%)	90	(1%)
Heterosexual Contact[6]	279	(3%)	472	(49%)	0	(0%)	751	(7%)
Mother at Risk for HIV	0	(0%)	0	(0%)	28	(88%)	28	(0%)
No Identified Risk[7]/Other	462	(5%)	148	(16%)	0	(0%)	610	(6%)
Total	10,034	(100%)	954	(100%)	32	(100%)	11,020	(100%)

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
6. Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.
7. No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.
10. Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

TABLE 5. WA STATE HIV[1] & AIDS CASES DIAGNOSED, KNOWN DEATHS, AND CASES PRESUMED LIVING, BY COUNTY OF RESIDENCE[8] AT DIAGNOSIS, AS OF 03/31/2005

	CASES DIAGNOSED					DEATHS				PRESUMED LIVING				
	HIV[1]	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**	*HIV[1]*	*HIV[1]*	AIDS	AIDS	*HIV[1]*	*HIV[1]*	AIDS	AIDS	**HIV/AIDS**
	No.	*(%)*	No.	(%)	**TOTAL**	*No.*	*(%)*	No.	(%)	*No.*	*(%)*	No.	(%)	**TOTAL**
	165	*(4.1%)*	609	(5.5%)	**774**	*11*	*(7.0%)*	320	(5.4%)	*154*	*(4.0%)*	289	(5.7%)	**443**
ADAMS CO.	*1*	*(0.0%)*	5	(0.0%)	**6**	*0*	*(0.0%)*	1	(0.0%)	*1*	*(0.0%)*	4	(0.1%)	**5**
ASOTIN CO.	*5*	*(0.1%)*	13	(0.1%)	**18**	*1*	*(0.6%)*	6	(0.1%)	*4*	*(0.1%)*	7	(0.1%)	**11**
COLUMBIA CO.	*1*	*(0.0%)*	4	(0.0%)	**5**	*0*	*(0.0%)*	3	(0.1%)	*1*	*(0.0%)*	1	(0.0%)	**2**
FERRY CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	6	(0.1%)	*0*	*(0.0%)*	1	(0.0%)	**1**
GARFIELD CO.	*1*	*(0.0%)*	0	(0.0%)	**1**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	0	(0.0%)	**1**
LINCOLN CO.	*0*	*(0.0%)*	5	(0.0%)	**5**	*0*	*(0.0%)*	2	(0.0%)	*0*	*(0.0%)*	3	(0.1%)	**3**
OKANOGAN CO.	*7*	*(0.2%)*	26	(0.2%)	**33**	*0*	*(0.0%)*	9	(0.2%)	*7*	*(0.2%)*	17	(0.3%)	**24**
PEND OREILLE CO.	*1*	*(0.0%)*	8	(0.1%)	**9**	*0*	*(0.0%)*	5	(0.1%)	*1*	*(0.0%)*	3	(0.1%)	**4**
SPOKANE CO.	*137*	*(3.4%)*	458	(4.2%)	**595**	*9*	*(5.7%)*	250	(4.2%)	*128*	*(3.3%)*	208	(4.1%)	**336**
STEVENS CO.	*4*	*(0.1%)*	20	(0.2%)	**24**	*0*	*(0.0%)*	8	(0.1%)	*4*	*(0.1%)*	12	(0.2%)	**16**
WALLA WALLA CO.	*7*	*(0.2%)*	52	(0.5%)	**59**	*1*	*(0.6%)*	26	(0.4%)	*6*	*(0.2%)*	26	(0.5%)	**32**
WHITMAN CO.	*1*	*(0.0%)*	11	(0.1%)	**12**	*0*	*(0.0%)*	4	(0.1%)	*1*	*(0.0%)*	7	(0.1%)	**8**
	127	*(3.2%)*	369	(3.3%)	**496**	*7*	*(4.4%)*	178	(3.0%)	*120*	*(3.1%)*	191	(3.7%)	**311**
BENTON CO.	*22*	*(0.6%)*	78	(0.7%)	**100**	*1*	*(0.6%)*	36	(0.6%)	*21*	*(0.5%)*	42	(0.8%)	**63**
CHELAN CO.	*13*	*(0.3%)*	35	(0.3%)	**48**	*1*	*(0.6%)*	21	(0.4%)	*12*	*(0.3%)*	14	(0.3%)	**26**
DOUGLAS CO.	*2*	*(0.1%)*	2	(0.0%)	**4**	*0*	*(0.0%)*	2	(0.0%)	*2*	*(0.1%)*	0	(0.0%)	**2**
FRANKLIN CO.	*18*	*(0.5%)*	43	(0.4%)	**61**	*1*	*(0.6%)*	14	(0.2%)	*17*	*(0.4%)*	29	(0.6%)	**46**
GRANT CO.	*10*	*(0.3%)*	31	(0.3%)	**41**	*1*	*(0.6%)*	19	(0.3%)	*9*	*(0.2%)*	12	(0.2%)	**21**
KITTITAS CO.	*4*	*(0.1%)*	15	(0.1%)	**19**	*0*	*(0.0%)*	8	(0.1%)	*4*	*(0.1%)*	7	(0.1%)	**11**
KLICKITAT CO.	*4*	*(0.1%)*	9	(0.1%)	**13**	*0*	*(0.0%)*	5	(0.1%)	*4*	*(0.1%)*	4	(0.1%)	**8**
YAKIMA CO.	*54*	*(1.4%)*	156	(1.4%)	**210**	*3*	*(1.9%)*	73	(1.2%)	*51*	*(1.3%)*	83	(1.6%)	**134**
	307	*(7.7%)*	876	(7.9%)	**1,183**	*16*	*(10.1%)*	443	(7.5%)	*291*	*(7.6%)*	433	(8.5%)	**724**
ISLAND CO.	*16*	*(0.4%)*	58	(0.5%)	**74**	*1*	*(0.6%)*	33	(0.6%)	*15*	*(0.4%)*	25	(0.5%)	**40**
SAN JUAN CO.	*6*	*(0.2%)*	19	(0.2%)	**25**	*0*	*(0.0%)*	10	(0.2%)	*6*	*(0.2%)*	9	(0.2%)	**15**
SKAGIT CO.	*26*	*(0.7%)*	53	(0.5%)	**79**	*3*	*(1.9%)*	29	(0.5%)	*23*	*(0.6%)*	24	(0.5%)	**47**
SNOHOMISH CO.	*213*	*(5.4%)*	599	(5.4%)	**812**	*10*	*(6.3%)*	295	(5.0%)	*203*	*(5.3%)*	304	(6.0%)	**507**
WHATCOM CO.	*46*	*(1.2%)*	147	(1.3%)	**193**	*2*	*(1.3%)*	76	(1.3%)	*44*	*(1.2%)*	71	(1.4%)	**115**
	443	*(11.1%)*	1,164	(10.6%)	**1,607**	*26*	*(16.5%)*	641	(10.8%)	*417*	*(10.9%)*	523	(10.3%)	**940**
KITSAP CO.	*74*	*(1.9%)*	199	(1.8%)	**273**	*1*	*(0.6%)*	109	(1.8%)	*73*	*(1.9%)*	90	(1.8%)	**163**
PIERCE CO.	*369*	*(9.3%)*	965	(8.8%)	**1,334**	*25*	*(15.8%)*	532	(9.0%)	*344*	*(9.0%)*	433	(8.5%)	**777**
	313	*(7.9%)*	914	(8.3%)	**1,227**	*13*	*(8.2%)*	454	(7.7%)	*300*	*(7.8%)*	460	(9.0%)	**760**
CLALLAM CO.	*18*	*(0.5%)*	49	(0.4%)	**67**	*2*	*(1.3%)*	27	(0.5%)	*16*	*(0.4%)*	22	(0.4%)	**38**
CLARK CO.	*137*	*(3.4%)*	403	(3.7%)	**540**	*2*	*(1.3%)*	199	(3.4%)	*135*	*(3.5%)*	204	(4.0%)	**339**
COWLITZ CO.	*35*	*(0.9%)*	89	(0.8%)	**124**	*1*	*(0.6%)*	49	(0.8%)	*34*	*(0.9%)*	40	(0.8%)	**74**
GRAYS HARBOR CO.	*13*	*(0.3%)*	49	(0.4%)	**62**	*1*	*(0.6%)*	29	(0.5%)	*12*	*(0.3%)*	20	(0.4%)	**32**
JEFFERSON CO.	*9*	*(0.2%)*	21	(0.2%)	**30**	*3*	*(1.9%)*	14	(0.2%)	*6*	*(0.2%)*	7	(0.1%)	**13**
LEWIS CO.	*9*	*(0.2%)*	41	(0.4%)	**50**	*1*	*(0.6%)*	25	(0.4%)	*8*	*(0.2%)*	16	(0.3%)	**24**
MASON CO.	*19*	*(0.5%)*	71	(0.6%)	**90**	*0*	*(0.0%)*	21	(0.4%)	*19*	*(0.5%)*	50	(1.0%)	**69**
PACIFIC CO.	*9*	*(0.2%)*	15	(0.1%)	**24**	*1*	*(0.6%)*	10	(0.2%)	*8*	*(0.2%)*	5	(0.1%)	**13**
SKAMANIA CO.	*0*	*(0.0%)*	7	(0.1%)	**7**	*0*	*(0.0%)*	5	(0.1%)	*0*	*(0.0%)*	2	(0.0%)	**2**
THURSTON CO.	*63*	*(1.6%)*	167	(1.5%)	**230**	*2*	*(1.3%)*	75	(1.3%)	*61*	*(1.6%)*	92	(1.8%)	**153**
WAHKIAKUM CO.	*1*	*(0.0%)*	2	(0.0%)	**3**	*0*	*(0.0%)*	0	(0.0%)	*1*	*(0.0%)*	2	(0.0%)	**3**
	1,355	*(34.0%)*	3,932	(35.7%)	**5,287**	*73*	*(46.2%)*	2,036	(34.4%)	*1,282*	*(33.5%)*	1,896	(37.2%)	**3,178**
	2,625	*(66.0%)*	7,088	(64.3%)	**9,713**	*85*	*(53.8%)*	3,890	(65.6%)	*2,540*	*(66.5%)*	3,198	(62.8%)	**5,738**
	3,980	*(100%)*	11,020	(100%)	**15,000**	*158*	*(100%)*	5,926	(100%)	*3,822*	*(100%)*	5,094	(100%)	**8,916**

1. Includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. Does not include those who have only been tested anonymously for HIV.
8. County of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing..

TABLE 6. WASHINGTON STATE HIV[1] CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 03/31/2005

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2001		2002		2003		2004[5]		2005 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	395	(92%)	1,156	(85%)	1,855	(85%)	3,406	(86%)	274	(87%)	264	(85%)	278	(85%)	291	(85%)	35	(85%)
Female	34	(8%)	212	(15%)	328	(15%)	574	(14%)	41	(13%)	47	(15%)	49	(15%)	53	(15%)	6	(15%)
Total	429	(100%)	1,368	(100%)	2,183	(100%	3,980	(100%	315	(100%	311	(100%	327	(100%)	344	(100%)	41	(100%
Race/Ethnicity[10]																		
White, not Hispanic	366	(85%)	1,057	(77%)	1,448	(66%)	2,871	(72%)	214	(68%)	200	(64%)	214	(65%)	216	(63%)	21	(51%)
Black, not Hispanic	42	(10%)	164	(12%)	376	(17%)	582	(15%)	47	(15%)	67	(22%)	59	(18%)	65	(19%)	7	(17%)
Hispanic (All Races)	10	(2%)	93	(7%)	212	(10%)	315	(8%)	33	(10%)	24	(8%)	32	(10%)	33	(10%)	8	(20%)
Asian/Pacific Islander	0	(0%)	1	(0%)	6	(0%)	7	(0%)	2	(1%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Asian	3	(1%)	25	(2%)	64	(3%)	92	(2%)	10	(3%)	7	(2%)	10	(3%)	11	(3%)	2	(5%)
Hawaiian/Pacific Islander	1	(0%)	0	(0%)	6	(0%)	7	(0%)	0	(0%)	1	(0%)	2	(1%)	0	(0%)	1	(2%)
Native American/Alaskan	5	(1%)	19	(1%)	41	(2%)	65	(2%)	5	(2%)	6	(2%)	8	(2%)	11	(3%)	1	(2%)
Multi-race	0	(0%)	2	(0%)	12	(1%)	14	(0%)	1	(0%)	4	(1%)	1	(0%)	6	(2%)	0	(0%)
Unknown	2	(0%)	7	(1%)	18	(1%)	27	(1%)	3	(1%)	2	(1%)	1	(0%)	2	(1%)	1	(2%)
Total	429	(100%)	1,368	(100%)	2,183	(100%	3,980	(100%	315	(100%	311	(100%	327	(100%)	344	(100%)	41	(100%
Exposure Category																		
Male/male sex (MSM)	293	(68%)	839	(61%)	1,346	(62%)	2,478	(62%)	192	(61%)	192	(62%)	206	(63%)	200	(58%)	23	(56%)
Injecting Drug Use (IDU)	45	(10%)	140	(10%)	204	(9%)	389	(10%)	26	(8%)	27	(9%)	25	(8%)	36	(10%)	4	(10%)
MSM and IDU	51	(12%)	117	(9%)	168	(8%)	336	(8%)	24	(8%)	30	(10%)	26	(8%)	26	(8%)	3	(7%)
Transfusion/Transplant	3	(1%)	7	(1%)	6	(0%)	16	(0%)	2	(1%)	0	(0%)	0	(0%)	2	(1%)	0	(0%)
Hemophilia	9	(2%)	4	(0%)	1	(0%)	14	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
Heterosexual Contact[6]	11	(3%)	137	(10%)	244	(11%)	392	(10%)	38	(12%)	41	(13%)	38	(12%)	35	(10%)	4	(10%)
Mother at Risk for HIV	3	(1%)	25	(2%)	7	(0%)	35	(1%)	0	(0%)	0	(0%)	1	(0%)	1	(0%)	0	(0%)
No Identified Risk[7]/Other	14	(3%)	99	(7%)	207	(9%)	320	(8%)	33	(10%)	21	(7%)	31	(9%)	44	(13%)	7	(17%)
Total	429	(100%)	1,368	(100%)	2,183	(100%	3,980	(100%	315	(100%	311	(100%	327	(100%)	344	(100%)	41	(100%
AIDSNET Region																		
Region 1	23	(5%)	52	(4%)	90	(4%)	165	(4%)	12	(4%)	15	(5%)	13	(4%)	21	(6%)	0	(0%)
Region 2	11	(3%)	40	(3%)	76	(3%)	127	(3%)	10	(3%)	15	(5%)	7	(2%)	11	(3%)	3	(7%)
Region 3	33	(8%)	124	(9%)	150	(7%)	307	(8%)	21	(7%)	16	(5%)	25	(8%)	26	(8%)	4	(10%)
Region 5	40	(9%)	167	(12%)	236	(11%)	443	(11%)	27	(9%)	37	(12%)	41	(13%)	25	(7%)	7	(17%)
Region 6	34	(8%)	116	(8%)	163	(7%)	313	(8%)	32	(10%)	22	(7%)	27	(8%)	28	(8%)	6	(15%)
Subtotal	141	(33%)	499	(36%)	715	(33%)	1,355	(34%)	102	(32%)	105	(34%)	113	(35%)	111	(32%)	20	(49%)
Region 4 (King Co.)	288	(67%)	869	(64%)	1,468	(67%)	2,625	(66%)	213	(68%)	206	(66%)	214	(65%)	233	(68%)	21	(51%)
Total	429	(100%)	1,368	(100%)	2,183	(100%	3,980	(100%	315	(100%	311	(100%	327	(100%)	344	(100%)	41	(100%

1 This includes persons reported with HIV infection who are not known to have progressed to AIDS as of this report date. It does not include those who have only been tested anonymously for HIV.

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection.

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

TABLE 7. WASHINGTON STATE AIDS CASES, YEAR OF DIAGNOSIS[3] BY GENDER, RACE/ETHNICITY,[10] EXPOSURE CATEGORY, AND AIDSNET REGION OF RESIDENCE[9] AT DIAGNOSIS, AS OF 03/31/2005

	1982-1989		1990-1997		1998-Current[5]		Cumulative		2001		2002		2003		2004[5]		2005 YTD[5]	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Gender																		
Male	1,88	(97%)	5,69	(92%)	2,46	(86%)	10,049	(91%)	355	(88%)	366	(83%)	366	(84%)	327	(83%)	28	(76%)
Female	62	(3%)	493	(8%)	416	(14%)	971	(9%)	47	(12%)	73	(17%)	69	(16%)	69	(17%)	9	(24%)
Total	1,95	(100%)	6,19	(100%)	2,87	(100%)	11,020	(100%)	402	(100%)	439	(100%)	435	(100%)	396	(100%)	37	(100%)
Race/Ethnicity[10]																		
White, not Hispanic	1,71	(88%)	4,92	(80%)	1,91	(66%)	8,544	(78%)	263	(65%)	283	(64%)	280	(64%)	262	(66%)	18	(49%)
Black, not Hispanic	130	(7%)	604	(10%)	485	(17%)	1,219	(11%)	73	(18%)	79	(18%)	69	(16%)	64	(16%)	14	(38%)
Hispanic (All Races)	75	(4%)	417	(7%)	317	(11%)	809	(7%)	46	(11%)	45	(10%)	57	(13%)	43	(11%)	3	(8%)
Asian/Pacific Islander	3	(0%)	32	(1%)	11	(0%)	46	(0%)	3	(1%)	4	(1%)	1	(0%)	0	(0%)	0	(0%)
Asian	11	(1%)	68	(1%)	53	(2%)	132	(1%)	5	(1%)	13	(3%)	10	(2%)	9	(2%)	2	(5%)
Hawaiian/Pacific Islander	5	(0%)	9	(0%)	12	(0%)	26	(0%)	0	(0%)	2	(0%)	5	(1%)	2	(1%)	0	(0%)
Native American/Alaskan	16	(1%)	117	(2%)	67	(2%)	200	(2%)	10	(2%)	11	(3%)	10	(2%)	10	(3%)	0	(0%)
Multi-race	1	(0%)	19	(0%)	13	(0%)	33	(0%)	0	(0%)	1	(0%)	3	(1%)	5	(1%)	0	(0%)
Unknown	0	(0%)	2	(0%)	9	(0%)	11	(0%)	2	(0%)	1	(0%)	0	(0%)	1	(0%)	0	(0%)
Total	1,95	(100%)	6,19	(100%)	2,87	(100%)	11,020	(100%)	402	(100%)	439	(100%)	435	(100%)	396	(100%)	37	(100%)
Exposure Category																		
Male/male sex (MSM)	1,50	(77%)	4,23	(68%)	1,60	(56%)	7,340	(67%)	237	(59%)	236	(54%)	246	(57%)	208	(53%)	19	(51%)
Injecting Drug Use (IDU)	83	(4%)	573	(9%)	342	(12%)	998	(9%)	43	(11%)	49	(11%)	49	(11%)	44	(11%)	2	(5%)
MSM and IDU	232	(12%)	608	(10%)	240	(8%)	1,080	(10%)	35	(9%)	39	(9%)	32	(7%)	31	(8%)	2	(5%)
Transfusion/Transplant	47	(2%)	64	(1%)	12	(0%)	123	(1%)	0	(0%)	1	(0%)	1	(0%)	3	(1%)	0	(0%)
Hemophilia	30	(2%)	52	(1%)	8	(0%)	90	(1%)	1	(0%)	0	(0%)	1	(0%)	1	(0%)	0	(0%)
Heterosexual Contact[6]	29	(1%)	372	(6%)	350	(12%)	751	(7%)	51	(13%)	71	(16%)	57	(13%)	54	(14%)	5	(14%)
Mother at Risk for HIV	8	(0%)	18	(0%)	2	(0%)	28	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)	0	(0%)
No Identified Risk[7]/Other	22	(1%)	272	(4%)	316	(11%)	610	(6%)	35	(9%)	43	(10%)	49	(11%)	55	(14%)	9	(24%)
Total	1,95	(100%)	6,19	(100%)	2,87	(100%)	11,020	(100%)	402	(100%)	439	(100%)	435	(100%)	396	(100%)	37	(100%)
AIDSNET Region																		
Region 1	79	(4%)	343	(6%)	187	(6%)	609	(6%)	19	(5%)	30	(7%)	27	(6%)	28	(7%)	1	(3%)
Region 2	48	(2%)	192	(3%)	129	(4%)	369	(3%)	18	(4%)	15	(3%)	21	(5%)	23	(6%)	1	(3%)
Region 3	111	(6%)	516	(8%)	249	(9%)	876	(8%)	29	(7%)	43	(10%)	39	(9%)	38	(10%)	5	(14%)
Region 5	171	(9%)	645	(10%)	348	(12%)	1,164	(11%)	57	(14%)	40	(9%)	38	(9%)	45	(11%)	6	(16%)
Region 6	108	(6%)	532	(9%)	274	(10%)	914	(8%)	52	(13%)	50	(11%)	30	(7%)	42	(11%)	6	(16%)
Subtotal	517	(26%)	2,22	(36%)	1,18	(41%)	3,932	(36%)	175	(44%)	178	(41%)	155	(36%)	176	(44%)	19	(51%)
Region 4 (King Co.)	1,43	(74%)	3,96	(64%)	1,69	(59%)	7,088	(64%)	227	(56%)	261	(59%)	280	(64%)	220	(56%)	18	(49%)
Total	1,95	(100%)	6,19	(100%)	2,87	(100%)	11,020	(100%)	402	(100%)	439	(100%)	435	(100%)	396	(100%)	37	(100%)

3 Year of diagnosis reflects the time at which disease was diagnosed by a provider. Year of report (not shown above) reflects the time at which a case report was received by the Department of Health.

5 Reporting delay is the period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials. Cases counts for more recent time periods are considered to be incomplete due to reporting delays.

6 Heterosexual Contact with a person who is known to be HIV infected or at increased risk for HIV infection

7 No Identified Risk includes patients for whom risk information is incomplete, cases still under investigation, and interviewed patients with no recognized HIV exposure category.

9 AIDSNET Region of residence at the time of testing positive for HIV (HIV cases) or at the time of AIDS diagnosis (AIDS cases). May not reflect where people are currently residing.

10 Collection and presentation of race/ethnicity data have been adjusted to be consistent with Census 2000 data collection and presentation methods. Consequently, data for Asian/Pacific Islanders are now collected and presented in two separate categories ("Asian" and "Hawaiian/Pacific Islander"), while historical data are presented in the "Asian/Pacific Islander" category. Those who report more than one race are presented in the "Multi-race" category.

* For explanation of revised AIDS total, see technical notes

WASHINGTON STATE REPORTED CASES OF CHLAMYDIA, GONORRHEA, EARLY SYPHILIS, JANUARY - MARCH 2005

	Chlamydia		Gonorrhea		Early Syphilis	
Sex	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Male	1,332	(26.7)	472	(54.3)	52	(94.5)
Female	3,657	(73.3)	398	(45.7)	3	(5.5)
TOTAL	**4,989**	**(100.0)**	**870**	**(100.0)**	**55**	**(100.0)**
Age						
0-14	71	(1.4)	8	(0.9)	0	(0.0)
15-19	1,594	(32.0)	185	(21.3)	2	(3.6)
20-24	1,892	(37.9)	244	(28.0)	7	(12.7)
25-29	734	(14.7)	133	(15.3)	4	(7.3)
30-34	276	(5.5)	92	(10.6)	7	(12.7)
35-39	163	(3.3)	71	(8.2)	17	(30.9)
40+	173	(3.5)	132	(15.2)	18	(32.7)
Unknown	86	(1.7)	5	(0.6)	0	(0.0)
TOTAL	**4,989**	**(100.0)**	**870**	**(100.0)**	**55**	**(100.0)**
Ethnic/Race						
White	2,190	(43.9)	359	(41.3)	44	(80.0)
Black	638	(12.8)	217	(24.9)	2	(3.6)
Hispanic	715	(14.3)	75	(8.6)	6	(10.9)
Native Hawaiian/Other Pacific Islander	52	(1.0)	5	(0.6)	0	(0.0)
Asian	187	(3.7)	16	(1.8)	1	(1.8)
Native American	150	(3.0)	21	(2.4)	0	(0.0)
Multi	137	(2.7)	14	(1.6)	2	(3.6)
Other	43	(0.9)	6	(0.7)	0	(0.0)
Unknown	877	(17.6)	157	(18.0)	0	(0.0)
TOTAL	**4,989**	**(100.0)**	**870**	**(100.0)**	**55**	**(100.0)**

Provider Type	**Cases**	**# Prov**	**Cases**	**# Prov**	**Cases**	**# Prov**
Community Health Ctr.	130	25	29	12	2	2
Emergency Care (Not Hosp.)	79	32	17	13	1	1
Family Planning	1,190	50	88	27	0	0
Health Plan/HMO's	166	31	34	13	1	1
Hospitals	436	70	133	46	0	0
Indian Health	51	12	10	8	0	0
Jail/Correction/Detention	225	26	60	17	2	2
Migrant Health	131	17	17	8	0	0
Military	219	6	25	4	0	0
Neighborhood Health	32	10	6	5	0	0
OB/GYN	320	83	24	18	0	0
Other	988	356	168	96	6	5
Private Physician	142	94	33	27	15	4
Reproductive Health	379	16	44	11	1	1
STD	317	19	157	10	27	1
Student Health	184	22	25	9	0	0
TOTAL	**4,989**	**869**	**870**	**324**	**55**	**17**

WASHINGTON STATE REPORTED STDs BY COUNTY JANUARY - MARCH 2005

	CT	GC	HERPES	P & S	EL	L/LL	CONG	TOTAL
Adams	14	3	3	0	0	0	-	0
Asotin	41	2	9	0	0	0	-	0
Benton	406	19	40	0	0	3	-	3
Chelan	169	2	27	0	0	2	-	2
Clallam	151	8	20	2	1	1	-	2
Clark	891	191	42	2	2	0	-	4
Columbia	9	0	0	0	0	0	-	0
Cowlitz	235	51	18	0	0	3	-	3
Douglas	85	2	8	0	0	1	-	1
Ferry	14	0	3	0	0	0	-	0
Franklin	192	7	11	0	0	0	-	0
Garfield	0	0	0	0	0	0	-	0
Grant	234	15	30	0	0	0	-	0
Grays Harbor	189	4	10	0	0	2	-	2
Island	177	14	35	1	0	1	-	2
Jefferson	37	3	11	0	0	0	-	0
King	5,335	1,266	700	123	39	65	-	227
Kitsap	672	70	54	4	4	3	-	11
Kittitas	94	3	8	0	0	0	-	0
Klickitat	41	8	3	0	0	0	-	0
Lewis	196	13	19	0	0	0	-	0
Lincoln	8	1	1	0	0	0	-	0
Mason	119	5	14	1	0	6	-	7
Okanogan	133	6	12	0	0	1	-	1
Pacific	33	1	3	0	0	0	-	0
Pend Oreille	14	1	4	0	0	0	-	0
Pierce	2,687	452	194	7	1	14	-	22
San Juan	21	0	5	0	0	0	-	0
Skagit	327	20	84	1	0	0	-	1
Skamania	19	2	3	0	0	0	-	0
Snohomish	1,635	166	286	8	2	14	-	24
Spokane	1,101	152	172	0	0	5	-	5
Stevens	44	2	6	0	0	0	-	0
Thurston	552	43	70	2	0	2	-	4
Wahkiakum	3	1	1	0	0	0	-	0
Walla Walla	138	8	23	0	0	0	-	0
Whatcom	462	65	87	0	0	3	-	3
Whitman	147	7	8	0	0	0	-	0
Yakima	1,002	198	125	0	2	9	-	11
YEAR TO DATE	4,989	870	530	41	14	51	0	106
PRV YR TO DATE	4,215	691	574	21	7	37	0	65
% CHANGE	18.4%	25.9%	-7.7%	95.2%	100.0%	37.8%	NC	63.1%

CT = Chlamydia Trachomatis
GC = Gonorrhea
HERPES = Initial Genital Herpes
P/S = Primary & Secondary Syphilis
EL = Early Latent Syphilis
L/LL = Late/Late Latent Syphilis
CONG = Congenital Syphilis

MONTHLY TUBERCULOSIS CASE TOTALS BY COUNTY, 2004-2005

	JAN		FEB		MARCH		APRIL		MAY		JUNE		JULY		AUG		SEP		OCT		NOV		DEC		TOTAL	
COUNTY	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**	**2004**	**2005**
Adams																									**0**	**0**
Asotin																									**0**	**0**
Benton			1						2										1						**4**	**0**
Chelan																									**0**	**0**
Clallam																									**0**	**0**
Clark		1		2	1	2			1		2								1		1		2		**8**	**5**
Columbia																									**0**	**0**
Cowlitz																									**0**	**0**
Douglas																									**0**	**0**
Ferry																									**0**	**0**
Franklin			1						1						1										**3**	**0**
Garfield																									**0**	**0**
Grant																									**0**	**0**
Grays Harbor						1																	1		**1**	**1**
Island									1				1				2				1				**5**	**0**
Jefferson																									**0**	**0**
King	8	8	12	5	7	15	15		6		19		18		4		11		9		7		17		**132**	**28**
Kitsap				1									1										1		**2**	**1**
Kittitas							1																		**1**	**0**
Klickitat																									**0**	**0**
Lewis			1																						**1**	**0**
Lincoln																									**0**	**0**
Mason																							1		**1**	**0**
Okanogan																									**0**	**0**
Pacific																									**0**	**0**
Pend-Oreille																									**0**	**0**
Pierce	1	1	2	4	1		2		1		9		1		4		2		1		3		7		**34**	**5**
San Juan																	1								**1**	**0**
Skagit						1					1								1						**2**	**1**
Skamania																									**0**	**0**
Snohomish		1		1		2			1		2		1		2		2		5		2				**15**	**4**
Spokane	3		1		1	4							1										1		**7**	**4**
Stevens																									**0**	**0**
Thurston		2	1						1		1						1		3						**8**	**2**
Wahkiakum																									**0**	**0**
Walla Walla						1													1						**1**	**1**
Whatcom	1	1		1	1		1				1								2						**6**	**2**
Whitman						1																			**0**	**1**
Yakima	2	1	3	1			1		1				1				2		1				1		**12**	**2**
State Total	**15**	**15**	**22**	**15**	**11**	**27**	**20**	**0**	**15**	**0**	**35**	**0**	**24**	**0**	**11**	**0**	**21**	**0**	**25**	**0**	**13**	**0**	**32**	**0**	**244**	**57**
YTD State Total		**15**	**37**	**30**	**48**	**57**	**68**	**57**	**83**	**57**	**118**	**57**	**142**	**57**	**153**	**57**	**174**	**57**	**199**	**57**	**212**	**57**	**244**	**57**	**244**	**57**

Note: Detailed analysis of tuberculosis morbidity is contained in "Washington State Tuberculosis Epidemiological Profile - 2002" and is available to order from the State TB Program by calling (360) 236-3443.

Deadline Details For *Washington State Responds* Quarterly Newsletter

The deadline for the next issue of ***Washington State Responds*** is **June 20, 2004**. The calendar start date for the issue is **August 5, 2005**. To submit information, corrections, or to be added or dropped from the mailing list, contact Barbara Schuler, Washington State Department of Health, HIV Prevention and Education Services, P.O. Box 47840, Olympia, WA 98504-7840. You may also telephone her at: (360) 236-3487 or call the Washington State Hotline at **1-800-272-2437, ext. 0** to leave a message**.** You may fax your information to (360) 236-3400, or preferably send via e-mail to: barbara.schuler@doh.wa.gov

We greatly appreciate news of your work or your organization!

Thank you for taking the time and effort to write, call, fax or e-mail!

DOH HIV/AIDS PREVENTION AND EDUCATION SERVICES

Disclaimers and Notice of HIV/AIDS Content

Washington State Department of Health HIV/AIDS Prevention and Education Services publishes information in this quarterly newsletter, ***Washington State Responds,*** as a courtesy to our readers, however, inclusion of information coming from outside of the Washington State Department of Health does not necessarily imply endorsement by the Washington State Department of Health.

The content of this newsletter is for informational purposes only and is not intended to be a substitute for professional medical advice, diagnosis or treatment.

This newsletter may contain HIV prevention messages that may not be appropriate for all audiences. Since HIV infection is spread primarily through sexual practices or by sharing syringe needles, prevention messages and programs may address these topics. If you are not seeking such information or are offended by such materials, do not visit this site.